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Nottingham City Council
Health and Adult Social Care Scrutiny Committee

Date: Thursday, 11 November 2021

Time: 10.00 am (pre-meeting for all Committee members at 9:30am)

Place: Ground Floor Committee Room, Loxley House, Station Street, Nottingham, NG2 3NG

Please see information at the bottom of this agenda front sheet about arrangements for ensuring Covid-safety.

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Senior Governance Officer: Jane Garrard **Direct Dial:** 0115 876 4315

If you need any advice on declaring an interest in any item on the agenda, please contact the Governance Officer shown above, if possible before the day of the meeting

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Nottingham City Council

Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held at Ground Floor Committee Room, Loxley House, Station Street, Nottingham, NG2 3NG on 14 October 2021 from 10.00am - 12.10pm

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Anne Peach
Councillor Cate Woodward (Vice Chair)	
Councillor Michael Edwards	
Councillor Samuel Gardiner	
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Angela Kandola	

Colleagues, partners and others in attendance:

John Brewin	-	Chief Executive, Nottinghamshire Healthcare Trust
Alison Newsham-Kent	-	Eating Disorders Service Manager, Nottinghamshire Healthcare Trust
Kazia Foster	-	Head of Transformation Mental Health Services, Nottinghamshire Healthcare Trust
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG)
Lisa Durant	-	System Delivery Director; Planned Care, Cancer and Diagnostics, Nottingham and Nottinghamshire CCG
Councillor Adele Williams	-	Portfolio Holder for Adults and Health
Jane Garrard	-	Senior Governance Officer, Nottingham City Council

31 Apologies for absence

Councillor Anne Peach (personal)

32 Declarations of interest

None

33 Minutes

The minutes of the meeting held on the 16 September 2021 were confirmed as a true record and signed by the Chair.

34 Adult Eating Disorder Service

John Brewin, Chief Executive, and Alison Newsham-Kent, Eating Disorders Service Manager, Nottinghamshire Healthcare NHS Foundation Trust attended the meeting

and gave a presentation about the Nottinghamshire Adult Eating Disorder Service. The following information was highlighted:

a) Nottinghamshire Adult Eating Disorder Service is a multi-disciplinary Team currently consisting of 9.7 whole time equivalents comprising nurses, occupational therapists, a dietician, consultant psychiatrist, psychology and administration staff.

b) The Service offers assessment, diagnosis and NICE compliant psychological interventions for adults with a diagnosed eating disorder, bulimia nervosa, and anorexia nervosa.

c) The number of individuals being referred to the Service has increased in comparison to previous years. In Nottinghamshire there were 307 referrals in 2019, in 2020 there were 313 and it is anticipated that by the end of 2021 445 referrals will have been made to the Service. The increase in referrals reflects the national picture.

d) The current average wait for an assessment is 37 days and the average wait for the first treatment is 43 days. There has been an increase in waiting times for the Service which had been most evident during the first Covid 19 'lockdown'.

e) The predominant ethnicity of those referred to the Service is 'White British' at 83%; the highest age group is 20-29 year olds; and only 10% referrals are for males. This is in line with national statistics.

f) The impact of Covid 19 had led to an increase in the number of referrals, an increase in waiting times, a reduction in face to face meetings and a shift from active therapy to supportive contacts. Staff sickness had been higher than average and this has significantly impacted the service due to size of the Team.

Kazia Foster, Head of Transformation Mental Health Services, Nottinghamshire Healthcare NHS Foundation Trust updated the Committee on the Severe Mental Illness Transformation. The following information was highlighted:

g) There is a large programme of works being undertaken in relation to Severe Mental Illness Transformation. £975million will be invested in services by 2023-24 to treat those suffering from severe mental illness. This will benefit over 370,000 people through the following improvements:
    - expanded access to support, care and treatment
    - increased access to psychological therapies
    - removal of thresholds
    - a 'no wrong door' approach
    - enabling choice and flexibility
    - facilitating a multi-sector approach
    - integration between services and providers
    - a person centred and strengths based approach.

h) The Adult Eating Disorder Transformation plan includes the expansion of the Team with a growth of 6.2 whole time equivalents over the next 6 months with improved medical monitoring. The Children's Eating Disorder Transformation Plan includes a growth of 8.4 whole time equivalents, from the current establishment of 10 clinical and 1.5 administrative staff. An Eating Disorder Transition worker will be recruited to support movement from children to adult services.

In response to questions from the Committee, and in the subsequent discussion the following points were made:

i) Internet research carried out by the Chair specifically relating to the service found images of underweight young white women in Trust documentation. The Chair commented that she did not consider this appropriate as it could be triggering for those suffering from an eating disorder and expressed disappointment that it was unrepresentative of those suffering from disordered eating.

j) Information had been submitted to the Chair in advance of the meeting by a member of the public who had received a letter from their GP stating that they could not be referred to the Service because they did not meet the BMI (Body Mass Index) criterion. The Trust stated that BMI is not used as a factor for acceptance to the Adult Eating Disorder Service, and a much broader range of measures are used. A patient who has been referred to the Service may be signposted to an alternative service if that is more clinically appropriate and some services do have BMI criteria that affects who can be referred to them. The Chair raised concern that, despite that assurance, this letter had been received by an individual and there could be other people receiving similar communication. In response, the Trust said that it would be willing to look at the particular case referred to for further investigation.

k) In response to a question about why not all referrals are accepted, even though they are made by health professionals who should knowledgeable about the Service, the Trust stated that assessment is carried out on the cognition and behaviours described in the referral prior to acceptance. In some cases, individuals may be referred because of significant fluctuations in weight but this could be attributable to another factor, such as trauma, and therefore the Eating Disorder Service may not be appropriate as weight/body image is not the primary issue. Instead, the Trust will signpost to a more appropriate alternative service. Any referrals that are not considered appropriate are recorded.

l) Referrals are screened on a daily basis to identify any individuals requiring urgent assessment. Other less urgent referrals are discussed at a weekly meeting to identify the most appropriate pathway.

m) Concern was raised that current difficulties in getting GP appointments could impact on referrals to the Service and the Trust was asked about the ability of individuals to self-refer. The Trust confirmed that there is currently no mechanism for self-referrals into the Service due to a lack of sufficient capacity in the Team. There is an ambition for people to have better access to the

Eating Disorder Service, including self-referral as already happens for child and adolescent services, and this will be explored once increased resource is in place. In the meantime, progress is underway to engage with other stakeholders and the community and voluntary sector to streamline accessibility to allow for earlier contact.

n) Committee members commented on the benefits of having a single point of access to prevent people getting rejected from multiple services and instead identify the most appropriate service and pathway at the outset. The Trust Chief Executive acknowledged that access to specialist services can sometimes be difficult and people often start by seeing GPs who may not having the skills or experience to refer appropriately. The NHS Long Term Plan and the Severe Mental Illness Transformation Plan, which both include ambitions for easier access, should help to address this.

o) The Trust considers that the Service is culturally competent but acknowledges that there is a need to explore further why there are relatively low numbers of patients from ethnic groups other than White British. There is also an aim to improve the representativeness of the Team to the population it serves.

p) Home visits are not provided by the Team but occupation health and community support workers are able to provide this to a very small number of people.

q) There are no specialist inpatient services in Nottinghamshire, and Nottingham patients usually receive inpatient care in Leicestershire through provider collaboration across the East Midlands.

r) As part of the Transformation Programme a number of improvements are underway which include looking at individuals who had not been diagnosed with a specific eating disorder but suffer from disordered eating, improving medical monitoring and increasing staffing levels. An investment of £394,000 to expand the current Adult Eating Disorder Team had been secured, with further investment planned as the model develops. One of the most significant challenges to improving the Service will be the recruitment of staff, especially at a time of increased demand.

s) The Trust is currently working with commissioners to develop a vision for what the Service will be like after transformation. A steering group, led by Nottingham and Nottinghamshire Clinical Commissioning Group, is developing a new service model and it is anticipated that the new model will be implemented within the next year. Service standards for severe mental illness are currently being tested nationally, but it is anticipated that there will be a target of a maximum four week wait across severe mental illness services.

The Committee welcomed the Trust's plans to improve access to the Adult Eating Disorder Service.

Resolved to

(1) request that Nottinghamshire Healthcare NHS Foundation Trust provide anonymised information on the reasons why referrals to the Adult Eating Disorder Service are not accepted; and further information, including patient feedback, on the transition from child to adult eating disorder services;

(2) hold an informal briefing for Committee members on the Severe Mental Illness Transformation Plan; and

(3) review Nottinghamshire Healthcare NHS Foundation Trust's progress in improving access to the Adult Eating Disorder Service in autumn 2022.

35 Update on Elective Recovery

Lucy Dadge, Chief Commissioning Officer, and Lisa Durant, System Delivery Director for Planned Care, Cancer and Diagnostics, Nottingham and Nottinghamshire Clinical Commissioning Group updated the Committee on the local position in relation to the impact that the Covid pandemic has had on delays in elective care and elective care recovery activity. The following information was highlighted:

a) The Covid-19 Pandemic had significant and far reaching implications across the NHS as hospitals responded to high numbers of patients with complex urgent needs. In direct response to the Covid-19 pandemic the NHS received an instruction to cease all non-urgent elective activity, and as a result waiting times increased.

b) Waiting times against the 18 week Referral to Treatment standard in Nottingham were proportionate to other local health systems and slightly better than the national position. Nottingham has always worked well in order to meet the 18 week treatment target and there is a real commitment to return to the pre-Covid position. In July 2021, performance against the 18 week standard was 71.6% compared to a target of 92%. This type of data is used to actively oversee elective patient waits.

c) Some individuals chose to wait longer for treatment due to Covid concerns.

d) There are still challenges associated with Covid-19 affecting elective recovery activity, including:
    i) capacity continues to be limited due to Infection Prevention and Control measures (IPC)
    ii) there is a need for clinical staff who worked tirelessly during the height of the pandemic to take leave to recover
    iii) pressures from urgent admissions continued during the summer
    iv) staff continue to test positive for Covid-19, creating gaps in resource across the health and social care system
    v) referrals reduced initially but are now increasing

e) Various methods of communication are used to engage with patients waiting for elective care and patients with a health concern were, and continue to be encouraged to seek advice without delay.

f) The risks of winter pressures on the NHS and elective recovery from the impact of Covid-19 are recognised, and therefore the system-wide 'winter plan' supports elective recovery.

g) Work is underway to build upon the existing cancer programme and it has been apparent that, at the onset of Covid-19, patients were reluctant to seek health advice. Cancer surgeries/treatments have been cancelled or delayed due to the pandemic and there is now a lot of pressure to address this. Emphasis is placed on the protection of elective beds for cancer patients and this is a matter of highest focus and priority. Focus therefore continued on earlier cancer diagnosis including:
    i. Targeted Lung Health Checks. This has been successfully rolled out in Mansfield and Ashfield since April 2021. Patient uptake has been high, with 2,000 patients scanned to date. The programme will be extended to Nottingham City in early 2022/23.
    ii. Rapid Diagnostic Centre pathways based around clinical pathways that offer a more holistic assessment. Investigations are coordinated to reduce hospital visits and the time to reach a diagnosis. Patients will have a single point of contact who will keep them informed of test results and next steps.

Councillor Adele Williams, Nottingham City Council Portfolio Holder for Adults and Health addressed the Committee and explained that there had been an incredible amount of hard work across all of the health systems in order to achieve the best outcomes for people during the Covid-19 pandemic. She acknowledged the importance of home care in supporting timely discharge from hospital that, in turn, creates capacity to support elective recovery activity. She welcomed the system funding that has been available. The Portfolio Holder noted that there had been some issues with recruiting social care staff in part, due to the initial lack of Personal Protective Equipment (PPE) at the beginning of the pandemic combined with low pay and a perceived low status of care sector workers. Issues with low pay and status remain and this affects the ability to recruit and retain staff.

In response to questions from the Committee and in the subsequent discussion, the following points were made:

h) The Independent Sector was used to provide elective care during the pandemic.

i) Treating patients in order of clinical priority is crucial with the primary aim being to offer fair, equitable access to elective care for all patients across the system based on clinical priority. There has been some very good joint working between the sectors and shared decision making for the benefit of patients, for example once waits have been reviewed, an individual's GP will be contacted to agree an approach which might include advice on keeping as well as possible, ways to prepare for surgery and other options available to the individual.

j) Emphasis is placed on patient empowerment and it is considered that good communication is key to this. Health inequality still remains. The disparity has not significantly changed and health inequality gaps in the City have not grown as a result of the pandemic, however there continues to be disproportionate

health issues amongst those classed as living in deprivation. This is recognised and focus has been placed on addressing the unacceptable variations in treatment and access to care.

The Committee agreed to consider carrying out a deep dive into a particular pathway to examine the specific actions being taken in relation to elective recovery and what difference those actions are making.

36 Work Programme

The Chair reported that, as agreed the previous meeting, the findings of the Care Quality Commission Well-led inspection of Nottingham University Hospitals NHS Trust, which was published in September 2021, and the action being taken to respond to those findings, will be considered by the Committee at its next meeting in November. Representatives of Nottingham University Hospitals NHS Trust, Nottingham and Nottinghamshire Clinical Commissioning Group and NHS England/ NHS Improvement have been invited to attend. There will also be an item on provision and access to GP services in the City.

The Committee noted its work programme for the remainder of 2021/22.

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Health and Adult Social Care Scrutiny Committee
11 November 2021

Nottingham University Hospitals NHS Trust – CQC Inspection

Report of the Head of Legal and Governance

1 Purpose

1.1 To scrutinise action being taken in relation to the findings of the recent CQC Well-led inspection of Nottingham University Hospitals NHS Trust.

2 Action required

2.1 The Committee is asked to consider the action being taken in response to the findings of the recent Care Quality Commission inspection of Nottingham University Hospitals NHS Trust; and whether:

a) it wishes to make any comment or recommendations; and/or
b) any further scrutiny is required and, if so, the focus and timescales.

3 Background information

3.1 In September 2021 the Care Quality Commission (CQC) published a report of its Well-led inspection, which took place in July 2021. The report can be viewed on the CQC's website. Following this inspection, the Trust was issued with a Section 29a warning notice under the Health and Social Care Act 2008 and rated as Requires Improvement, with an Inadequate rating in relation to whether services are well-led.

3.2 The Committee is aware that in October 2020 the CQC downgraded maternity services provided by NUH and since then the Committee has spoken to representatives of the Trust twice about the provision of maternity services and work taking place to make improvements. The Chair of the Committee has also spoken with Nottingham and Nottinghamshire Clinical Commissioning Group about its independently led thematic review of incidents relating to maternity care at NUH. A number of the Committee's concerns about maternity services relate to the Trust's governance and culture. The Committee has scheduled a further review of the Trust's progress in improving maternity services for spring 2022.

3.3 The focus for this meeting is on the response to the CQC's report of its Well-led inspection of NUH.

3.4 NUH has been invited to attend the meeting to outline its current position, what action it has taken so far and what it intends to do. The Trust has submitted a written update from the Acting Chief Executive, which is attached. The Acting Chief Executive and Chief Nurse will be attending the meeting to answer questions from the Committee.

3.5 The Committee also felt it was appropriate to speak to other organisations involved in supporting, and holding the Trust to account for its improvement. Therefore, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has been invited to attend the meeting to discuss its perspective and role in relation to supporting NUH in improvement. A written briefing from the CCG is attached and the CCG's Chief Nurse will be attending the meeting to speak with, and answer questions from the Committee.

3.6 NHS England/ NHS Improvement was also contacted in relation to its role as trust regulator to get its perspective and discuss its role in relation to supporting improvement. It was not possible for a representative of the organisation to attend this meeting, but it has agreed to have a separate discussion with representatives of the Committee.

4 List of attached information

4.1 Update from Nottingham University Hospitals NHS Trust

4.2 Nottingham and Nottinghamshire Clinical Commissioning Group Oversight and Assurance Briefing: Nottingham University Hospitals

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Care Quality Commission (15 September 2021) 'Nottingham University Hospitals NHS Trust Inspection Report'

6.2 Minutes of meetings of the Health and Adult Social Care Scrutiny Committee on 14 January and 15 July 2021

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
jane.garrard@nottinghamcity.gov.uk
0115 8764315

An update from Nottingham University Hospitals NHS Trust

November 2021

In my first update to you as Acting Chief Executive, I wanted to share the four priorities I have set for the Trust over the next few months.

The NHS faces a period of unprecedented pressure with the ongoing pandemic, high levels of emergency patients and the growing number of patients who are waiting for diagnostic or elective treatments. We are no exception to this, hence the need to make sure we have clarity on where our focus should lie. The areas we will be concentrating our efforts on:

1. **Delivering a safe, caring and productive winter** - We have seen unprecedented levels of emergency patients for this time of the year [emergency attendances: 126,965 April - October 2021/22 compared to 94,596 April - October 2020/21 / emergency admissions: 34,499 April – October 2021/22 compared to 29,249 April – October 2020/21], and with the ongoing pandemic and the winter months ahead, we will need to be creative in how we manage our capacity and workforce to deliver the very best we can for our patients. I am conscious that high volumes of emergency patients can not only stretch our teams ability to deliver care to the standard that we all want, but also compromise the capacity we have available for patients awaiting diagnosis and care on our urgent and elective pathways. I am also well aware of the impact it is having on staff, physically and emotionally.

   We are having constructive discussions with our partners within the NHS, in social care and other sectors to determine how we can combine our efforts to deliver the most we can for our patients over winter.
2. **Workforce** - In our conversations with clinical and supporting teams, the issue of greatest concern being raised is about having sufficient workforce numbers available to allow us to do our jobs to the best of our ability. I want to have a real focus on recruitment, retention and absence so that we can maximise the workforce available to us over the next few months as we know the pressures on our services are going to be high.
3. **Responding to our regulators concerns** - We have to respond to concerns raised by regulators, particularly the CQC reports on maternity and leadership. We wish to see all of our services and our leadership attracting the highest levels of ratings from our regulators, and to achieve this we must correct the shortfalls they have pointed out in their most recent reports.
4. **National capital investments** - We are in the fortunate position to have three capital projects that are progressing through the regional or national planning and approval processes (maternity and neonatal expansion, the national rehabilitation centre, and Tomorrow's NUH). All of these projects will improve the services that we can offer to patients, and provide a much improved working environment for our staff; I am keen that we do not delay their progress.

Delivering a safe, caring and productive winter

Throughout the summer our hospital services have been operating under the kind of sustained pressure that we would normally only see in the most difficult winter periods. We face a combination of managing Covid patients, an increase the numbers of people accessing emergency care, and managing the backlogs of planned patients created during the pandemic. This means that we have to make very difficult clinical decisions on a daily basis to prioritise patients into limited capacity.

For the Committee's information, at the end of the report is a table that shows patient activity in 2021/22 compared to 2020/21. The current numbers of Covid positive inpatients (as at Monday 1 November 2021 we had 96 Covid positive patients, 15 of those on Critical Care).

We continue to work together with our system partners in health and social care to speed up the discharge of medically safe patients (patients who require support to leave hospital, such as a social care package or a community bed). On an average day we have between three and five wards full of patients who no longer need hospital care and are waiting a discharge; this means these beds are then not available for emergency, cancer or elective patients. Whilst our target is to have no more than 37 inpatients waiting for discharge; we currently have 222 patients awaiting discharge (data correct on 3 November).

The system discharge cell has, and continues to agree schemes to reduce the volume of medically safe patients' delayed in hospital waiting for discharge. These schemes include: additional community beds; support from the British Red Cross; Sciensus support for patients requiring healthcare at home; and increased fast track capacity via Tuvida. We are working with our partners to ensure that patients leave the hospital as soon as they are declared medically fit to do so in order that our hospital capacity is available to treat as many patients as we can.

Recent work with system partners, following a summit to focus on our approach to winter, agreed four work streams. They are:

- Front door working group, looking to provide services to patients in their normal setting to avoid emergency admissions to hospital
- Discharge working group, to support the discharge of patients as soon as they are ready to leave the hospitals
- Risks and Triggers working group , to determine the trigger points when escalation actions should be activated, and
- Workforce working group, looking at opportunities across providers to improve the workforce situation.

Workforce

The challenges the NHS has faced over the past two years have led to some staff describing that they are feeling exhausted and some even considering leaving the NHS altogether. This is a national issue, not just one in Nottingham.

We intend to focus on work to retain those staff we have and improve the environment and organisation they work in, including their well-being, whilst also working on promoting Nottingham as place people want to choose to start or continue their careers. Some of that work we will do with partners across the health and system.

Work on this programme is just starting, but we will be happy to share more with the Committee as this work progresses.

Responding to our regulators concerns

As the Committee is aware, we have in the past year had two CQC reports that point to services that need improving. Our current ratings for the organisation stand at:

In October 2020 the CQC downgraded our maternity service and since then we have been working with our partners and regulators to make improvements. We meet with them monthly to update on progress against a set of key measures and metrics.

In September 2021 the CQC published their report following their Well-led inspection which took place during July 2021. Our ratings are now:

After the well-led inspection we were issued with a Section 29a warning notice under the Health and Social Care Act 2008 that requires us to make significant improvement in the following areas:

- Improving the connection between the board and the wider organisation;
- Ensuring that there is collective leadership at board level;
- Ensuring that measurable action is taken to address bullying and that all staff, including those with particular protected characteristics under the Equality Act, are treated equitably;
- Ensuring that there are effective structures, processes and systems of accountability in place to support the delivery of our organisational strategy;
- Ensuring that all levels of governance and management function effectively and interact with each other appropriately;
- Ensuring that when things go wrong we investigate and learn lessons (safety and safeguarding incidents and events);
- Ensuring that there are robust arrangements for identifying, recording and managing risks, issues and mitigating actions;

- Ensuring that there are comprehensive assurance systems, and performance issues are escalated appropriately through clear structures and processes.

The CQC return on 28 January 2022 to ensure that we have made progress on the areas outlined above to give them enough confidence to remove the warning notice.

Below is an update on progress for the areas of well-led and maternity:

Well-led: Since the publication of the report the Trust executive team have been doing a number of things. We have been meeting with staff to talk through the detail of the report. This has been either through large staff sessions or members of the Executive Team attending team meetings. We have apologised for the effect this may have had on you and our organisation, and for any impact on our patients and community, including loss of confidence in our services. By far the strongest reactions have been around cultures of bullying, racism and issues with inclusion. We have heard staff concerns and are absolutely determined to tackle these head on. We want to be really clear: bullying, racism and barriers to inclusion will not be tolerated in any form. We want every member of staff to feel safe, secure and happy coming into work - without fear of facing bullying or discrimination - so that we can all work to our greatest potential. Our pledge to our staff is that we will not stop until we put this right.

Working with senior leaders across the trust, we have begun to create a plan for how we want our organisation to be led and how we want to develop leaders, and as part of that we will be engaging staff in co-creating solutions to the challenges we are facing.

The Board and Executive Team continue to be visible, visiting areas across our sites and attending meetings we have been invited to, along with meeting with individual staff who want to raise their concerns directly to us. Our plan to address the CQC requirements will be presented to our November Trust Board meeting and progress against key milestones reported to future Board meetings.

We aim to develop an open, inclusive and compassionate leadership to create the positive culture our organisation deserves. We are happy to share regular updates with the Committee over the coming months, along with any detailed information the Committee needs for assurance.

Maternity: We continue with our maternity improvement programme monitoring improvements in service delivery via a Maternity Dashboard and set of Bellwether indicators that we continue to develop. These are available to the Committee.

We continue to encourage the voices of women and families for learning and improvements in our service and at the September Trust Board a couple shared their poor experience and the service were able to talk about improvements they were making. We have recently received and welcomed a report from the Maternity Voices Partnership about the experiences of women who used maternity services in Nottingham and Nottinghamshire during the COVID-19 pandemic and how the COVID-19 pandemic and associated restrictions in maternity care impacted on pregnancy, birth and the postnatal period. A number of actions to improve the experience of women, birthing people and their families have been planned as a result.

As a service we continue to have ongoing challenges with staffing shortages and this was recognised by the Clinical Commissioning Group in their Insights visit carried out the week commencing 27th October. Our campaign to recruit newly qualified and more experienced midwives continues with 32 midwives joining in September and October and a further 12 arriving before the end of the year.

To support recruitment and retention we have projects in place, including 'Golden Hello's', local inductions and flexible working approaches. We are also taking advantage of a collaborative regional bid to recruit international midwives, with 15 midwives allocated to our maternity service. We have also recruited to key leadership roles within midwifery which will bring much needed stability and resilience once these individuals take up their posts

We continue to support the wellbeing needs of staff with counselling and access to the Nottinghamshire Staff Support Hub, which we widely and regularly promote, along with the Trust's extensive wellbeing offer. During 'International Week of Happiness at Work' in September we ran a 'Kindness Matters' campaign, a key part of our culture change plans.

The CQC report highlighted a number of concerns about digital systems and capability. Over the last few months there has been a number digital improvements which include:

- Maternity Advice Line went public. **Benefit to women**: one single point of contact staffed 24/7 instead of multiple numbers, expert advice always available, call queue so you don't get a busy tone, escalation in place if required (e.g. induction to Labour Suite or ABC)
- Updates and upgrades to our Maternity information system. **Benefit to women**: more consistent care, better record keeping and lower risk of things being missed due to mandatory fields and other quality improvements becoming required.
- Virtual Desktop Interface rolled out in the community. **Benefit to women**: faster connection speeds for midwives making it easier for midwives to document in patient notes giving more quality face to face time with women in their appointments
- More eObs devices in the Trust. **Benefit to women**: Midwives can complete electronic observations faster which increases quality of care, and observations are more available to midwives which means they can better monitor women and respond more quickly to concerns
- NUH Mailboxes have been rolled out in the Community. **Benefit to women**: referrals made from City or Queens are now guaranteed to be picked up on time, where they had been missed before
- ***Coming Soon***: New Part 1s which will provide better information to women, MEDWAY PAS in the Community which will improve midwives' ability to provide care and increase appointment efficiency.

Progress on our maternity improvement programme is reported to each Trust Board meeting and is reported monthly to a quality assurance meeting chaired by ICS with regulator and patient representation.

Independent maternity review: The Clinical Commissioning Group and NHS England/ Improvement have commissioned an independently-led review. It started on 1November and will last for a period of 12 months. This review is completely independent of Nottingham University Hospitals, but we will fully support the review and will provide access to records and staff to aid its findings and conclusion.

National capital investments

Tomorrow's NUH: We continue to work with the New Hospital Programme on our plans to redevelop our two main hospital sites, QMC and City hospital between 2025 and 2030.

We have further developed the clinical model which will inform our plans, incorporating feedback from the East Midlands Clinical Senate review, as well as from engagement with our teams and stakeholders.

The timeline for the submission of the Pre-Consultation Business Case (PCBC) is expected to be confirmed by the CCG Governing Body in November. Public consultation is scheduled for 2022, and will be informed by further pre-engagement with the public and stakeholders. The CCG will bring the proposals for the consultation to the scrutiny committees in due course.

In addition an Outline Business Case for the construction of a multi-storey car park on the QMC site has also now been completed and is going through the appropriate internal approval processes. This is a key enabling scheme needed to release space for the creation of 'development zones' for construction on the site in the future.

Maternity and neonatal expansion programme: The Outline Business Case to secure £29.6m capital funding to invest in neonatal and maternity services at the QMC and to cover the costs of necessary enabling works is currently pending approval from regional NHS England and Improvement, as well as support from the local Integrated Care System and advice from the scrutiny committees in relation to how we consult with the public on the proposed change..

This is for redevelopment and significant expansion of the current neonatal space at QMC, resulting in an additional 21 neonatal cots and eight more maternity beds. It would also allow for refurbishment and redevelopment of the two obstetrics theatres to expand the available theatre space. Under these proposals, the neonatal cot number would increase from 17 to 38 (as set out in the separate paper from the Clinical Commissioning Group) thereby addressing current capacity issues and ensuring compliance with the National Neonatal Critical Care Transformation Review (published December 2019).

Assuming all approvals are secured and subject to engagement with relevant citizens and stakeholders, enabling works are proposed to begin in mid-2022, and the intention is for the expansion to be completed by the end of 2023. The expansion programme is in line with the emerging proposals contained in the Tomorrow's NUH programme, of bringing together all women's and children's services together onto one site aligned with emergency care. The urgency of current lack of cot capacity means that we cannot wait for the 2030 timescale of the Tomorrow's NUH programme to undertake this work.

National Rehabilitation Centre: Following detailed design, clinical and commercial reviews by NHS England and Improvement and the New Hospital Programme between January - October 2021, the Outline Business Case for the National Rehabilitation Centre is now ready for review by the Joint Investment Committee and then HM Treasury later this year.

The national funding allocation for the programme is £81m, and the residual capital gap of £9m has now been underwritten by the local Integrated Care System, although philanthropic efforts to provide additional capital continue. The National Rehabilitation Centre is therefore now a fully funded scheme.

Work continues on the clinical model and workforce preparation with the first four adverts going live this month for Advanced Care Practitioners to work at the National Rehabilitation Centre. These roles take three years to train and will start in January.

The most significant risk for the programme is now the timeline, as the period for the development of the final business case has now been condensed to six months. However, the necessary clinical and academic work needed to provide content for the final business case is already underway.

Given the significance of the clinical and academic partnership to the National Rehabilitation Centre programme, it is particularly important that the timeline of opening to patients in October 2024 is adhered to so that there is alignment with the universities' academic year.

The New Hospital Programme has formally confirmed P22 as the procurement route for the programme, and the New Hospital Programme will provide overarching governance. The New Hospital Programme will start the tender process for a contractor as soon as approval has been received from Joint Investment Committee. Modern methods of construction have been factored into the build, and this should help to shorten the construction period to 18 months.

Conclusion

We, along with NHS Trust's across the country, face a particularly busy period over the next six months to continue to deliver high quality services to our patient at a time of unprecedented demand. We will do this alongside supporting our staff, making progress on regulatory improvement plans and national investment priorities.

Rupert Egginton, Acting Chief Executive, Nottingham University Hospitals NHS Trust
November 2021

Hospital Activity 2020/21 compared to 2021/22

	New OP Appts		Follow Up OP Appts		Elective Admissions		Daycases		Admissions from ED		Emergency Operations		Planned Operations		ED Attendances	
	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21	2021/22
April	10,549	24,620	43,559	63,599	617	1,371	3,907	8,188	3,086	4,858	7,873	12,625	444	1,062	9,183	16,172
May	12,012	24,573	40,579	64,403	687	1,589	4,280	8,707	3,805	5,160	9,283	13,272	517	1,297	12,321	18,308
June	15,966	27,199	52,707	71,888	864	1,813	5,765	9,356	4,155	5,109	10,866	13,120	760	1,374	13,217	18,715
July	17,740	24,623	58,326	68,961	1,109	1,685	6,879	9,231	4,543	5,136	11,817	13,815	883	1,256	15,093	18,533
August	18,379	22,157	52,029	60,680	1,201	1,285	6,993	8,421	4,540	4,741	12,101	12,707	928	1,097	15,231	17,637
September	22,922	25,404	64,264	69,032	1,668	1,478	8,512	8,969	4,634	4,701	12,740	12,450	1,246	1,154	15,160	18,538
October	22,528	22,252	62,591	57,878	1,262	1,322	8,472	8,272	4,486	4,794	12,998	12,598	949	837	14,391	19,062
November	23,368		64,489		1,027		7,818		4,323		12,455		722		13,440	
December	22,207		61,173		1,070		7,877		4,466		12,624		736		13,103	
January	23,423		60,377		959		7,387		4,261		12,494		718		12,021	
February	22,548		59,754		953		7,178		3,959		11,317		713		11,885	
March	27,111		72,558		1,263		8,958		4,744		12,927		947		15,672	

Please note that not all outpatient appointments will be outcomed and recent months' data may be incomplete

NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG OVERSIGHT AND ASSURANCE BRIEFING

NOTTINGHAM HEALTH SCRUTINY COMMITTEE

NOTTINGHAM UNIVERSITY HOSPITALS

Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has been working closely with Nottingham University Hospitals NHS Trust (NUH), CQC and NHS England and NHS Improvement (NHSEI) over the past year to oversee improvements in maternity services and more widely across the trust. This briefing will aim to summarise the work and illustrate system oversight arrangements in the relation to all services being provided at NUH.

System Approach

1.1 As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services, NHS Nottingham and Nottinghamshire CCG plays an integral role in ensuring we get the best care and outcomes for our local population. The CCG supports local improvement, working in line with the trust regulator (NHS England and Improvement) and the regulator for the quality of services (Care Quality Commission). The regulators have legal powers of intervention and the CCG monitors quality standards, instigating improvement actions where required

1.2 As we transition to the proposed new statutory arrangements (Integrated Care Systems) it is essential that there is a shared ambition for health and wellbeing of our citizens.

1.3 The Integrated Care Board (ICB) will take on the duties of the CCG in terms of local quality oversight and improvement. This will require close collaboration working with system partners (including providers, people using services, NHS England and NHS Improvement, regulators, and wider partners), shared quality improvement priorities and shared ownership of risks.

1.4 Our ICS and current CCG approach has clear governance and escalation processes for quality (including safety) in place, and actively monitors and manages system quality risks, in a way that enables continual learning and improvement.

1.5 In preparation for this transition, a system-wide Quality Assurance & Improvement Group (QAIG) has been established. This group will report into the ICB Quality Committee however in the interim reports into the ICS Board and NHS Nottingham and Nottinghamshire CCG Quality & Performance Committee.

1.6 QAIG has been established to ensure the system works collaboratively across health and care partners to support, improve, and sustain high quality care across Nottingham and Nottinghamshire:

- To ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation; and
- To continually improve the quality of services, in a way that makes a real difference to the people using them

The group takes a proactive and systemic approach to managing and improving quality drawing on evidence, best practice and quality improvement methodologies in a way that is transparent and measurable.

1.7 The CCG and the ICS act in accordance with the National Quality Board taking the responsibility for monitoring the quality and safety of health and care services as per Local Quality Requirements:

- **QUALITY PLANNING**: Work to a common definition of quality
- **QUALITY IMPROVEMENT:** Deliver quality improvement and develop a core set of quality metrics which can be used to measure quality
- **QUALITY CONTROL**: Contribute and embed quality oversight with a shared commitment to working together

2. Nottingham University Hospitals (NUH)

2.1 As part of enhanced surveillance on maternity services at NUH a Safety Oversight and Quality Assurance Group for NUH Maternity was established during January 2021. As part of information and intelligence it was evident that the concerns identified within maternity were more widespread and commissioner oversight was enhanced. Appendix A provides more detail of the maternity assurance actions.

2.2 Additionally, routine quality assurance arrangements identified a number of concerns, beyond those identified in maternity around wider organisational culture, safety, effectiveness, and experience of care.

2.3 During May 2021 the CCG formally sought assurances around the quality of care being provided across the Trust, to further understand the steps being taken to address operational demands plus recovery and restoration of services following the pandemic.

2.4 To support this the CCG worked with NUH to identify and populate a set of 'Key Issues and Risks' (KIARs) outlining the actions being taken plus the system support required to ensure the necessary improvement. In addition to identifying the impact of increased operational demands this exercise identified a number of specialist services experiencing staffing and resource challenges, making them fragile and vulnerable to disruption of provision. These included services such as Maternity, Emergency Department (ED), Urology, and more recently Oncology, specifically chemotherapy.

2.5 As a result of these challenges and associated KIARs the recommendation from QAIG (August 2021) to the ICS board (and CCG Quality and Performance Committee) that NUH to be under enhanced surveillance so that there is greater scrutiny and the formation of a system action plan to o identify opportunities to utilise the system mutual aid offers, support NUH to build a positive learning culture and work as a system to ensure the best outcomes for our citizens

2.6 A system action plan has been developed with collaboration from NUH. In the past few months system mutual aid has been used to support operational pressures in maternity and emergency care, as well as supporting improvements in NUH internal governance and oversight.

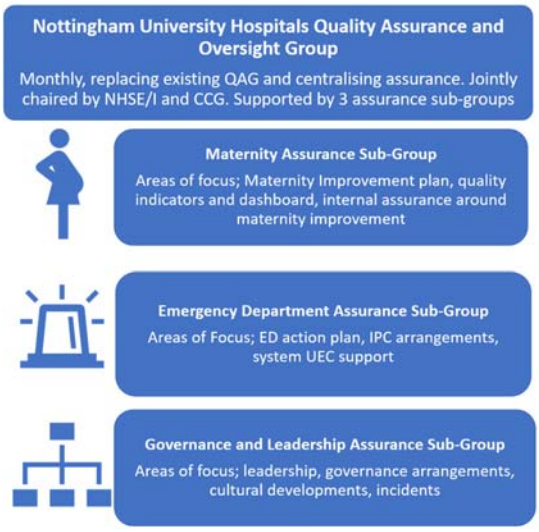
2.7 In September Trust have received an overall CQC rating of Requires Improvement following a focussed Well-Led Inspection and visits to surgery and the emergency department. The report highlighted many areas which have been identified as part of our system quality oversight, and additional concerns in relation to a culture of bullying across the organisation.

3. NUH Commissioner Actions/Involvement

3.1 Enhanced surveillance and system/regulatory support will continue, the CCG and ICS continue to work closely with Nottingham University Hospitals NHS Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge.

3.2 We have Established a system oversight framework (detail in Appendix B) to monitor progress of both immediate safety plus the transformation and change programme. This includes establishing an Oversight and Quality Assurance Group (QAG) co-chaired by the CCG Accountable Officer and NHSEI Regional Chief Nurse (Midlands), with three focussed assurance subgroups which will provide oversight and support for the improvement programme. Representation includes Healthwatch, Professional Bodies, Health Education England, Care Quality Commission (CQC), and Local Authority Public Health.

3.2.1 Figure 1 High Level Oversight Arrangements



3.3 In addition, quality and safety oversight continues with increased touchpoints with NUH. This includes CCG representatives at a number of internal NUH meetings such as the Incident Review Meetings, Harm Free Groups, Corporate Quality Committee, Maternity Oversight & Operational Groups. Relationships have also been established with the new

Chief Nurse, new Director of Midwifery, and new Associate Director of Quality Governance and teams.

3.4 A programme of system supported quality insight visits are being planned, including a system Winter preparedness visit to the Emergency Department.

3.5 The CCG has also established weekly triangulation meetings incorporating Contracting, Commissioning, Quality, Recovery and Transformation leads to ensure there is a consistent and up to date view of quality.

3.6 It is recognised that quality monitoring and oversight needs to evolve to ensure that we operate in an environment which is proactive and at the forefront of improvement. Historical approaches have been responsive and reliant on key performance indicators which are not necessarily always able to provide the 'whole story' in terms of what quality looks and feels like. As a system we have agreed a set of quality principles which will underpin a single view of quality.

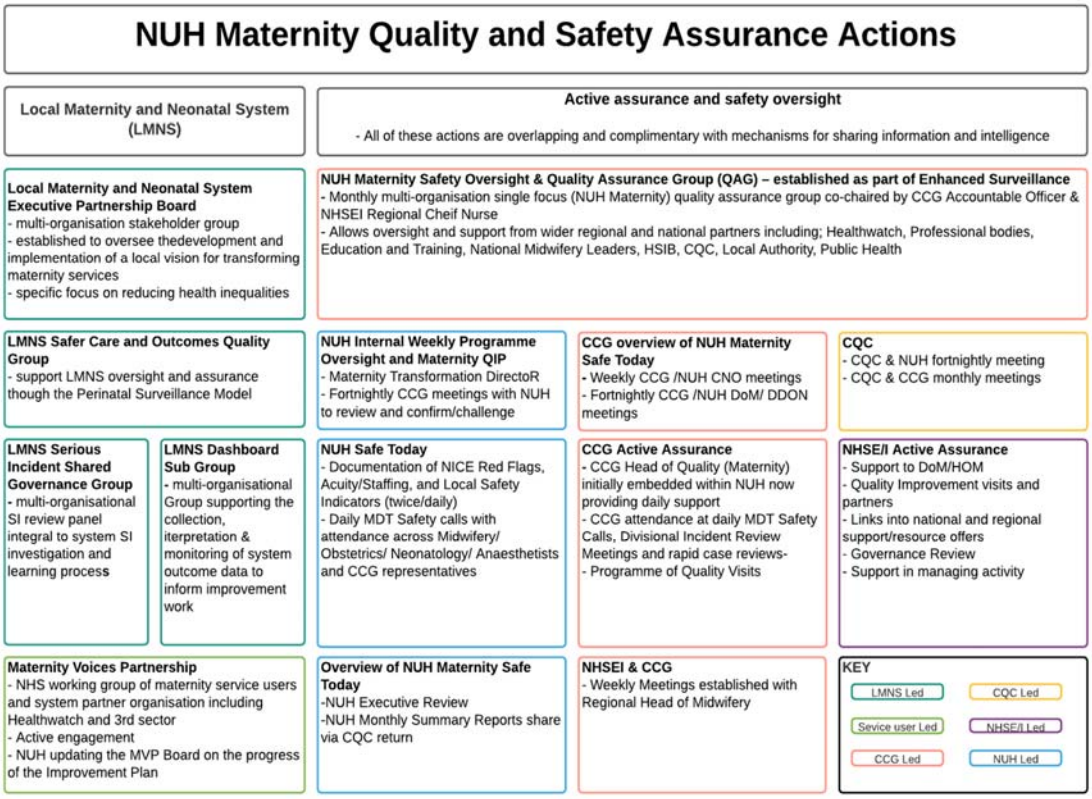
3.7 Since January 2021 there has been a Maternity focussed QAG however concerns persist in this are due to the lack of pace and assurance seen across the NUH Maternity Improvement Programme and a lack of focus on impact and outcomes. Although there has been considerable work to develop a meaningful Improvement Plan and a Provider Maternity Dashboard there is still not clear triangulation between these or the challenges the maternity service faces. Improvement progress, in maternity particularly has been hindered by the change in critical leadership roles (there have been four Directors of Midwifery and three Chief Nurses in eight months) as well as the on-going operational demands.

3.8 An Independent Review of NUH Maternity Services has been jointly commissioned by the CCG and NHSEI Midlands Regional team to drive rapid improvements to maternity services in Nottingham by focussing on issues where change is urgently needed. The Review will analyse a broad range of information from complaints, incidents, concerns, and family experiences, but will also have a clear focus on current practice to ensure that the appropriate standards of safety and quality are being delivered.

3.9 The Review will be completely independent of NUH, includes involvement from families and the findings and report will be made public when complete. We are committed to ensuring that affected families will be kept up to date and involved throughout the review. Families will shape the Terms of Reference (Appendix C), membership and engagement in the Reference Panel and a written monthly update will be provided to all families and interested parties.

3.10 Whilst the situation at NUH is far from where we want it to be, we recognise that rating of 'outstanding' for caring is testament to the staff working there. However, patients, citizens and staff should be receiving much better care and leadership. We are committed to working with system partners and the Trust to support improvement, expecting better to be delivered so we can ensure that our citizens receive the excellent care that they deserve.

Appendix A NUH Maternity Quality Assurance



Appendix B - NUH Assurance Oversight Framework

ENHANCED SURVEILLANCE: Monthly meeting jointly chaired by CCG and NHSE/I with 3 active subgroups; acting as collaborative improvement and assurance group

- **MATERNITY:** Monthly multi-organisation single focus (NUH Maternity) quality assurance group chaired by CCG Chief Nurse. Allows oversight and support from wider partners and oversight from trust engagement and review of progress against Maternity Improvement Plan
- **ED:** To Be Established. Areas of Focus: ED action plan, IPC arrangements, UEC support incl. surge plans, workforce
- **GOVERNANCE, LEADERSHIP, CULTURE:** To be Established. Areas of focus: Leadership & Workforce, Governance arrangements, Cultural Development, Incident Management

ICS/NHSEI System Review Meeting

Nottingham University Hospitals (NUH) Quality Assurance Oversight Group

ICS Executive Leadership Board

System Assurance, Support, & Oversight

ICS Quality Assurance & Improvement Group

NUH Maternity Safety & Assurance Oversight Group

NUH Emergency Department Oversight Group

NUH Governance, Leadership & Culture Oversight Group

NUH Quality & Safety Oversight Committee
Provider-wide focus on Key Issues & Risks (KIAR). CCG in attendance. KIARs with system support plan reports ICS Quality

NUH/CCG Monthly Executive Meeting
Support & Review of CQC Well Led

NHSEI Regulatory Assurance & Support
- Quality Improvement Partner
- Insight Visits
- Links into national and regional support/resource offers as part of SOF 4 package
- Monthly regulatory review meetings
- NHSEI seconded support

Care Quality Commission (CQC)
- CQC & NUH fortnightly meeting - review action plans
- CQC & CCG monthly meeting

NUH Maternity Improvement Programme

System Support / Working Groups

LMNS Executive Partnership Board

ICS Capacity & Planning

ICS Infection Control Assurance Group

ICS A&E Delivery Board

ICS Patient Safety Specialist Group

ICS People & Culture Board

ICS Planned Care Board

Cancer Programme Board

Diagnostics

Elective & Outpatients Transformation

NUH Oversight & Operational MIP Meetings
NUH Maternity Transformation Programme Director / support from NHSEI Improvement Partners
Fortnightly Meetings with CCG in attendance to support assurance, provide confirm/challenge

NUH Maternity SafeToday
Daily MDT Safety calls with attendance across Midwifery/ Obstetrics/ Neonatology/ Anaesthetists and CCG representative

LMNS Perinatal Surveillance Group
focus on quality and safety outcomes; areas for improvement

LMNS SI Shared Governance
Multi-agency panel in place to focus on maternity serious incidents and learning; reps include subject matter experts from across the system and network, provider reps, CCG

CCG / NUH Contracting Interface

CCG Assurance, Support, & Oversight

- NUH/CCG Contract Executive Board
- Activity & Finance Ops Group
- Tomorrows NUH Long COVID/Post COVID & Neutralising Monoclonal Antibodies

CCG Information Sharing

EXAMPLES OF REFRESHED WORKING ARRANGEMENTS
- Review of programme of quality insight visits
- Weekly triangulation meetings (contracting/ commissioning/ quality/ recovery & transformation)
- Increased touchpoints with both Executive Teams and Quality Teams
- System/CCG support and improvement plans - Key Issues & Risks (KIARs)
- Mutual aid
- CCG Head of Quality (Maternity) providing daily support (Maternity SafeToday)
- CCG attendance internal NUH meetings e.g. Divisional/Corporate Incident Review Meetings, Maternity Rapid Case Reviews, Quality & Safety Oversight Committee, Harm Free Care
- Involvement in review of ED 12 hour breaches and lessons learned
- IPC support and focus on IPC BAF / cleanliness / estate / and social distancing

NUH Led
CCG Led
System
Regulatory
New Oversight Groups

Appendix C - Independent Maternity Review Terms of Reference

TERMS OF REFERENCE

Independently led thematic review of incidents relating to maternity care at the Nottingham University Hospitals NHS Trust (the Review)

Introduction

1. In response to concerns regarding the quality of maternity services at Nottingham University Hospitals NHS Trust (the Trust), enhanced oversight and surveillance processes were put in place by NHS England and NHS Improvement (NHSE/I) and the NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) during Autumn 2020.

2. A system oversight framework was established, monitoring progress of both immediate safety concerns and the Transformation & Change Programme; this aims to provide oversight and support for the NUH Maternity Improvement Programme. Partners from the Nottingham and Nottinghamshire Local Maternity & Neonatal System (LMNS) put increased scrutiny processes in place of untoward events and serious incidents at the Trust, whilst also working with the Trust to retrospectively review a number of maternity incidents.

3. This enhanced oversight identified a failure to learn from incidents and investigations, and also the potential for a number of incidents, complaints and concerns in relation to maternity care that may not have been appropriately identified, reviewed or escalated.

4. NHSE/I and the CCG recognise that the maternity care provided by the Trust has not been of the quality required, and that issues remain ongoing. NHSE/I and the CCG are committed to improving the quality and safety of the services that women, people who require medical terminations, people who give birth and their families receive from the Trust.

5. NHSE/I and the CCG will therefore commission an independently led review of maternity services at the Trust. The review will be known as the *'Independent thematic review of incidents relating to maternity care at the Nottingham University Hospitals'* ('the Review') and will be undertaken by an independent Review Team ('the Review Team').

6. NHSE/I and the CCG recognise that significant work has already been undertaken nationally in relation to commissioned maternity reviews. This includes the learning and recommendations made most recently in the form of immediate and essential actions arising from the Ockenden Review of maternity services at the Shrewsbury and Telford NHS Hospital Trust (2020)[1] . It was acknowledged in those findings '*that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change'.*

7. NHSE/I and the CCG will therefore seek to trial a new approach to maternity review, that captures local themes, trends and learning in order to inform specific and measurable actions for rapid improvement. This Review will examine both current and

[1] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

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recent concerns with maternity services at the Trust, in order to explore correlating trends, causation and connections, recognising that concerns may have previously been seen as isolated or individual events.

8. While the Review will consider the significant body of evidence already available, it will also identify additional evidence required from the Trust, NHSE/I, the CCG and wider system, in order to gain insights into current and recent maternity practice, culture and processes. The Review will also work with women, people who give birth and families to ensure the Review learning and recommendations reflect people's lived experience.

9. Throughout the period of the Review, NHSE/I and the CCG will continue to work closely with the Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge to the Trust's maternity improvement plans. The Review will ensure key areas of learning are fed into that process and that this informs the NUH Maternity Improvement Programme.

10. This Review does not replace the statutory processes that exist around the response to individual cases, the duty of candour, notification of incidents, concerns relating to individual practitioners or other obligations relating to the provision of care by the Trust, either retrospectively or prospectively.

11. **In order to deliver a thematic Review, the Review Team will consider the detail of individual cases. However, it is recognised that the Review Team may identify individual cases which require further action or investigation; such as retrospective significant events, complaints or concerns, and/or where professional referrals are required.**

12. **An Independent Investigation Team (IIT) will therefore be established in order to undertake these investigations. This Independent Investigation Team will only complete individual investigations identified as being required by the Review Team, and this will be completed in line with national guidance, policy and best practice.**

13. **The IIT process will ensure that individual, retrospective case investigations are not tied to the Review timescales. The process will ensure that specific answers or outcomes are provided where possible to women, people who require medical terminations, people who give birth and families affected. While the IIT process will run separately to the Review, it will be overseen by the Review's independent Programme Director to ensure that actions from these investigations are reported back to inform maternity improvement at LMNS and Trust level.**

14. **Terms of Reference for the IIT will be devised by the Programme Director and independent Clinical Leads upon commencement of the Review.**

15. In the future, serious incidents, significant events, cases, complaints, concerns or professional referrals will be subject to a strengthened process, overseen by the LMNS, as recommended by the Ockenden Report. To facilitate this, the Nottingham and Nottinghamshire LMNS Perinatal Surveillance Quality Group have established a Serious Incident Shared Governance Group, which includes external clinical specialist opinion from outside the Trust.

16. It is recognised that ongoing support will be required for families affected by their experience of maternity services at the Trust. While separate to the Review, the CCG

and NHSE/I (as joint commissioners of the Review) will work with the Trust to ensure that there are appropriate and robust support services in place.

Purpose of the Review

17. The Review will provide an independently led assessment of what has happened with the Trust's maternity services and identify lessons and conclusions, including but not limited to the following:

    a. Determining if the systems and processes adopted by the Trust to identify and report serious incidents and harm are in line with national guidance, fit-for-purpose and effective;
    b. Identify any areas to support future recognition of concerns to allow earlier intervention;
    c. Identifying any service related themes/wider issues or links that are apparent from this Review;
    d. Evaluating the Trust's approach to risk management and implementing lessons learnt from HSIB and other internal investigations;
    e. Assessing the Trust's governance arrangements and making recommendations to address any identified gaps from Board to ward;
    f. Reviewing all identified themes against the Trust's current quality improvement work.

18. The Review will draw conclusions as to the adequacy of the actions taken at the time by the Trust and organisations surrounding the Trust, including the CQC, NHSE/I and the CCG. Taking account of improvements and changes made, the Review will aim to provide lessons helpful to the Trust in ensuring appropriate actions are taken to improve maternity services.

19. NHSE/I, the CCG and the Trust will act upon the findings of the Review and ensure the learning and recommendations are incorporated into the maternity improvement programme. The Trust will be expected to implement the recommendations from the Review.

Scope of the Review

20. The Review will consist of four component areas:

    A. **Data & Analytics:** a review of data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors.
    B. **Detailed Review & Key Lines of Enquiry:** examining current and recent concerns with maternity services at the Trust and investigating specific themes and trends, in order to gain insights into practice, culture and processes.
    C. **Listening to Women, People Who Require Medical Terminations, People Who Give Birth and Families:** ensuring that the Review incorporates the learning and experience of those with lived experience of maternity services at the Trust
    D. **Review of the Governance & Oversight of Maternity Services at the Trust:** looking at the levels of assurance to ensure the safety and quality of service provision

A. Data & Analytics

21. The Review will examine data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors. This will support the identification of any strategic issues or events within the Trust that may have had a bearing on the way that maternity services were run.

22. It is acknowledged that themes and trends may pre-date 2006. However, as 2006 represents the inception of the Trust, it is not possible to obtain or extract data and information prior to this date.

23. The Review will examine a number of information and data sources to support the identification of themes and trends. These will not be considered in isolation and, where possible, will be correlated in order to identify any interconnecting themes, issues or trends. Information and data sources will include (but not be limited to) the reporting of:

    a. Serious incidents (including, but not limited to fetal medicine, intrapartum stillbirths, neonatal deaths, maternal deaths and babies with severe injuries) – numbers, themes and trends
    b. Healthcare Safety Investigation Branch (HSIB) referrals and recommendations made
    c. Incidents which have been internally recorded by the Trust (including incidents recorded as low or no harm) – numbers, themes and trends
    d. Near misses - numbers, themes and trends
    e. All coronial cases held and, where relevant, resultant Prevent Future Death reports
    f. Number and types of litigation proceedings issued in relation to maternity care
    g. Concerns and/or complaints that have been lodged to or from any source about maternity care at the Trust – numbers, themes and trends
    h. Cases of maternal admission to ITU following delivery
    i. Maternity cases resulting in a referral to the General Medical Council (GMC) / Nursing and Midwifery Council (NMC) / Health and Care Professions Council (HCPC)
    j. Professionals referred to the General Medical Council (GMC) / Nursing and Midwifery Council (NMC) / Health and Care Professions Council (HCPC)
    k. Staffing vacancies, turnover and professional supervision within maternity and the wider trust
    l. Findings of staff surveys in relation to the Trust's culture, in particular the prevalence and effectiveness of the patient safety culture
    m. Staff complaints, whistleblowing and Freedom to Speak Up (FTSU) concerns– numbers, themes and trends
    n. Staff training and compliance
    o. Data and information collated within the Trust for the purposes of assurance and monitoring.
    p. Data shared with the Trust's regulators and commissioners in relation to quality, activity, assurance and monitoring

B. Detailed Review & Key Lines of Enquiry

24. The Review will examine current and recent concerns with maternity services at the Trust and investigating specific themes and trends, in order to gain insights into practice, culture and processes. The Review will expedite and examine themes and

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Key Lines of Enquiry (KLOEs) identified using a clear methodology, as well as learning from the review of data and management information.

25. This detailed element of the Review will consider a number of Key Lines of Enquiry and use the appropriate evidence to do so. While a number of KLOEs will emerge as the Review progresses, the following areas may be included:

    a. Improvement & Improvement Culture: Where internal reviews or regulatory / externally commissioned reviews into the Trust's maternity services have taken place in the past:
        i. Has the learning been implemented?
        ii. Have all required changes to practice been sustainably embedded in the Trust?
        iii. How were the recommendations and actions assured?
        iv. Were the actions specific, measurable and/or adequate?
        v. Are staff able to articulate the actions that were implemented, or the impact of actions implemented?

    b. How, in the individual cases which were referred to the coroner and to HSIB, did the Trust respond and seek to learn lessons? Did the Trust provide appropriate support and compassionate care to families after these referrals?

    c. Communication:
        i. How far are women, people who require medical terminations, people who give birth and their families listened to, and communicated with, in an open, honest and transparent way?
        ii. How far do women, people who require medical terminations, people who give birth and their families feel informed about their health and care, or the health and care of their child?
        iii. How far do women, people who require medical terminations, people who give birth and their families feel engaged in decision-making?

    d. How robustly do the Trust share information with families following an early termination, neonatal death, maternal injury or other high-harm event?

    e. Does the Trust provide compassionate, respectful and culturally-sensitive care?
        i. Is sensitive care provided to families affected by early termination, neonatal death, maternal deaths and babies with severe injuries?

    f. Following early termination, neonatal death, maternal injury or other high-harm event, does the Trust have robust, practical arrangements in place to support women, people who require medical terminations, people who give birth and their families?
        i. Are there processes and procedures in place that are followed?

    g. Is there documented evidence of a timely verbal and written apology to women or people who give birth, as a part of the duty of candour process?
        i. Does the Trust do this now?
        ii. Are staff trained in, and confident around, the duty of candour process?
        iii. The Review will quantify both the volume and themes of incidents, complaints, concerns and Freedom to Speak Up (FTSU) concerns in relation to maternity care within the Trust and will include an examination of Trust policies and procedures directly applicable to the Review.

h. How robust are the Trust's maternity triage processes?

i. How robust are the Trust's systems in relation to post-mortem and pathology following neonatal or maternal incident?

j. What infrastructure, training and resources are in place to ensure that Trust effectively supports pregnant women and pregnant people who have pre-existing mental health needs?
    i. What infrastructure, training and resources are in place to ensure that the Trust effectively supports women and people who give birth who develop post-natal mental health conditions?

k. How robust are the Trust's current processes around record-keeping and information sharing?
    i. What processes are in place to ensure that accurate, timely medical information is shared between maternity units?
    ii. Does the Trust have a robust process in place for securely sharing medical notes with women, people who give birth and their families?
    iii. Are these processes routinely followed?

l. Did the Trust's Quality Assurance Framework ensure the effective reporting, investigation and monitoring of serious incidents in line with the NHS Serious Incident Framework and Trust policies?

m. Where individual cases have been identified through any source, were these recognised appropriately? Are there any gaps in the identification and investigation of individual cases?

n. How did the Trust respond to complaints and concerns raised with them by women, people who require medical terminations, people who give birth and their families in relation to the maternity services?
    i. How did the Trust seek to engage and learn from these?

o. How did the Trust respond to whistleblowing or Freedom to Speak Up (FTSU) concerns raised by staff in relation to the maternity services?
    i. How did they seek to engage and learn from these?

p. For maternity staff departing the Trust, have exit interviews been completed? How has the feedback informed service improvement, staff experience and workforce development?

q. Does the Trust have a maternity service that is culturally-competent? How far do services provide differential care to women, people who require medical terminations, people who give birth and their families from underrepresented groups?

r. How far does the maternity workforce represent the demographics of the people it cares for?

s. How does the Trust assure itself that it is following national guidelines and appropriately updating internal policies in line with this, across all aspects of fetal medicine, maternity care and neonatal care?

C. Family Group

26. The Review Team will work independently with women, people who require medical terminations, people who give birth and their families to establish a Family Group. The purpose of the Family Group is to ensure that women, people who require medical terminations, people who give birth and their families can share their experiences of the Trust's maternity services with the Review Team, in order to inform learning, themes and recommendations.

27. The Family Group will be led by an independent Chair or representative from the Group (the "Chair"). The Chair will support the work of the Review Team and act as an independent advocate, to ensure that the voice of those with lived experience is effectively captured. In supporting the Review Team, the Chair will not have access to any patient-identifiable information.

28. The Family Group will be publicised using a variety of communication methods, in order to be as open and accessible as possible. Families can join the Family Group at any stage throughout the Review process.

29. The Review Team will ensure that members of the Family Group receive regular progress updates on Review activity. The Review Team will ensure that updates and communications are accessible and are shared via a range of methods.

30. The Review Team and Chair of the Family Group will seek to ensure that the Family Group is representative of the population served by the Trust's Maternity Services. This will ensure that the Family Group has appropriate representation from: Black, Asian and minority ethnic (BAME) families; lesbian, gay, bisexual, transgender and queer (LGBTQ+) communities; Gypsy, Roma and Traveller (GRT) communities; and other underrepresented groups.

D. Review of the Governance & Oversight of Maternity Services at the Trust

31. The Review Team will consider whether the Trust has had, and continues to have, governance and oversight arrangements in place to ensure appropriate identification and actions related to themes emerging from incidents, complaints and concerns at all levels.

Review Timescales

32. The Review will update NHSE/I, the CCG, the Trust, the LMNS Board and the Trust's Quality Assurance Framework Group at regular intervals throughout the Review to ensure that learning can support the active maternity improvement journey underway within the Trust.

33. The Review set-up, including the recruitment of staff and ratification of the Terms of Reference, will take place in October 2021. Clinical Reviews will commence from November 2021.

34. The Review will aim to complete and share the final report with NHSE/I, the CCG Governing Body (or other relevant statutory body), the Trust Board, the LNMS and Quality Assurance Groups within 12 calendar months of commencement.

35. The findings of the Review will be made publically available through public facing LMNS Board and Integrated Care Board papers.

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Protocol

The final protocol and methodology will be jointly agreed by the Review Lead, NHSE/I and the CCG in line with the principles outlined here.

Principles Underpinning the Review

- Women, people who require medical terminations, people who give birth and families involved in the Review will be treated with compassion and kindness, and appropriate support will be provided for all those who are engaged in the Review
- Women, people who require medical terminations, people who give birth and families who share their story as part of the Review will be provided with appropriate and robust support services, should they require ongoing support
- The Review will accept the experiences and stories of women, people who require medical terminations, people who give birth and families as truth
- The Review will be led by an independent Programme Director, supported by a strong project management office (PMO) structure to support timely delivery against objectives and adopting an evidence-based approach
- The Review Lead, expert clinical panels, investigators and specialist advisors will be independently appointed and have no association or connection to the Trust
- In order to remunerate members of the Review Team, CCG business mechanisms may need to be used. In doing so, this will not mean that members of the Review Team are “employees” of the CCG
- There will be a clear Scheme of Delegation and Review Programme Plan in place, to ensure that the Review remains independent and cannot be curtained by NHSE/I or the CCG
- The Trust will cooperate with the Review, including supplying documentation, as and when requested
- The Review Team will develop an independent Communication and Engagement Strategy, to ensure that all families and stakeholders who wish to receive updates and communications do so
- There will be a clear, consistent methodology used to undertake the review which will be determined by the Review Lead, NHSE/I and the CCG
- All personal and special category data accessed for the Review will be accessed and stored in accordance with the Data Protection Act (2018), the UK General Data Protection Regulation (GDPR), CCG and NHSE/I policies
- At no point in the Review will cases, incidents, concerns or complaints be considered “historic”, in recognition that harm and loss is not historic for the families affected
- This Review does not replace the statutory processes that exist around the response to individual cases, the duty of candour, notification of incidents or other obligations relating to the provision of care by the Trust either retrospectively or prospectively
- The Review will look in detail only at those individual cases for which consent is granted to access the records pertaining to the case
- The Review conclusions will be shared with the wider system via the Trust's Maternity Quality Oversight Group and other ICSs and NHSE/I quality oversight and assurance routes

NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG

MATERNITY IMPROVEMENT DETAILED BRIEFING

HEALTH SCRUTINY COMMITTEE

The Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has been working closely with Local Maternity & Neonatal System (LMNS) partners over the past year to oversee improvements in maternity services and implement Urgent Clinical Priorities following the publication of the interim Ockenden Report (December 2020).

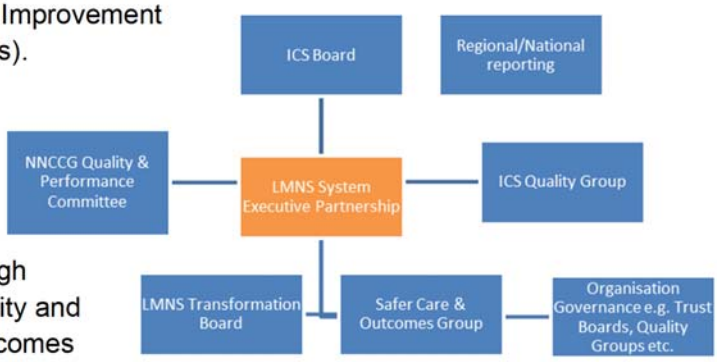
This briefing will aim to summarise the work and illustrate maternity improvement system oversight arrangements in addition the progress specifically in relation to Nottingham University Hospitals Maternity Services.

1. System Approach to Maternity Assurance & Quality

1.1 As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services NHS Nottingham and Nottinghamshire CCG plays an integral role to ensure we get the best maternity care and outcomes for our local families.

1.2 The CCG is key partner of the Nottingham and Nottinghamshire Local Maternity & Neonatal System (LMNS). The LMNS Executive Partnership Board is currently chaired by the Chief Nursing Officer of Nottingham and Nottinghamshire Integrated Care System (ICS) and CCG.

1.3 LMNS representatives include Executive Leads from both of the maternity providers (Sherwood Forest Hospitals and Nottingham University Hospitals), Nottingham and Nottinghamshire Maternity Voices Partnership (MVP), CCG, Local Authority Public Health, and NHS England and NHS Improvement Head of Maternity Network (Midlands).



1.4 The LMNS has a specific role in overseeing delivery of the national priorities to tackle health and care inequalities focusing on the transformation and delivery of high quality, safe and sustainable maternity and neonatal services and improved outcomes and experience for woman and their families. As collaborative partners the LMNS Executive Partnership Board drives the LMNS Programme to deliver sustained improvements in safety, equity, quality and outcomes.

Appendix A describes system partnership roles across the LMNS.

1.5 The Ockenden Report recommends that increased authority and accountability is given to LMNS' to ensure the safety and quality in the maternity services they represent. During

June 2021 Terms of Reference and LMNS work programmes were reviewed to ensure that the LMNS purpose specifically included key Ockenden deliverables:

LMNS Ockenden Deliverables 2021/2022	Nottingham and Nottinghamshire Position
Oversight of quality in line with implementing a revised perinatal quality surveillance model	Perinatal Quality Surveillance oversight through the LMNS Perinatal Quality Surveillance Group (previously Safer Care & Outcomes Group) reporting into the LMNS Partnership Executive Board and ICS Quality Committee. The Group will lead on the production of a local quality dashboard which brings together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMNS. The Group will take timely and proportionate action to address any concerns identified and building this into local transformation plans. The onus should be on trusts to share responsibility for making improvements, making use of strengths in individual neighbouring trusts within the LMNS to ensure that learning and data gathered through perinatal improvement work is shared across the ICS to inform wider delivery improvement.
To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.	An LMNS Dashboard Sub Group (DSG) is now in place (August 2021) reporting into the LMNS Perinatal Quality Surveillance Group aim to create a perinatal surveillance system dashboard to support the collection, interpretation & monitoring of system outcome data for both perinatal surveillance and improvement purposes. The DSG is chaired by the CCG Head of Quality (Maternity) with representatives from across maternity and neonatal services, system analytics and public health. An external analytics company has been commissioned to support the development of a dashboard. There is a two to three year time lag in publishing national maternity and perinatal mortality data and we need to do more to oversee and understand local outcomes. NHS Digital released a major update to the Maternity Services Data Set (MSDS) in April 2019 which enables clinical data to be collected for great insight. Improved data quality is absolute focus for the LMNS.
To oversee local trust actions to implement the immediate and essential actions from the Ockenden report	Trusts are required to submit quarterly reports to NHS England and NHS Improvement (NHSEI) regarding compliance with the 7 Immediate and Essential Actions described in the Ockenden report. A process is in place for the LMNS to review provider submissions with a focus on quality assurance and action plans. See Appendix B for further detail.
To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care	The national Perinatal Equity Strategy will be reviewed by the LMNS Board once available. Early work to address health inequalities has commenced e.g. the perinatal mental health work stream is currently developing a health inequalities action plan informed by local data and information about access and engagement with local perinatal mental health services. This plan will drive forwards actions that are aimed at improving access to services across the perinatal mental health care pathway. Currently, every woman is provided with a paper Personalised Care and Support Plan (PCSP). Whilst the plan is reviewed throughout the pregnancy, work over the next year will focus on the quality of the plans and embedding their use with both women and

	professionals during the maternity journey. This will include training of the workforce in shared decision making and the principles of choice and personalisation. Plans to digitise PCSP's on Patient Knows Best public facing digital app will support with the embedding of quality PCSP. Both NUH and SFH are developing plans to ensure that they have the building blocks of continuity of carer in place to support women to have personalised care delivered by a consistent person.
To co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships (MVP)	Currently in Nottingham and Nottinghamshire there is a MVP which is an independent, multi-disciplinary advisory body, made up of local parents, representatives and professionals who evolved from the Maternity Service Liaison Committee. Our committee currently includes representatives from NUH and SFH with both midwifery and obstetric representatives attending; CCG; Nottingham City and County Local Authorities; HealthWatch; Small Steps Big Changes (SSBC), and doulas. At each meeting there are several service users who have used Nottinghamshire maternity services and have volunteered to be active members of our MVP. MVP volunteers with the support of HealthWatch have undertaken several engagement activities including 'walking the patch', '15 Steps' and themed surveys.
To implement shared solutions wherever possible through shared clinical and operational governance	A LMNS Serious Incident (SI) Shared Governance Group has been established (April 2021) reporting into the LMNS Perinatal Quality Surveillance Group. This is a multi-organisation collaborative group of system and regional subject matter experts (representatives include leads for midwifery, obstetrics, and neonatology both NUH and SFH; NHSE/I; Maternity Neonatal System Improvement Partners (MatNeoSiP) Clinical Leads; and ICS Patient Safety Specialists). The principal duties of the group are to lead on the scrutiny, oversight and transparency of all maternity-related incidents which meet the following criteria identified as serious incidents with a focus on shared learning and the development of recommendations which will support providers to initiate impactful quality improvement work. The Group is responsible for identifying common causal factors and themes to support oversight and improvement.

2. Nottingham University Hospitals NHS Trust Maternity Services - Commissioner Actions/Involvement

2.1 In response to concerns regarding the quality of maternity services at Nottingham University Hospitals (NUH) enhanced surveillance was initiated during Autumn 2020. Actions included:

- Temporary release of midwifery subject matter expertise to establish and support SafeToday (December 2020 – April 2021)
- Establishing regular information sharing meetings and touch-points at both Executive and Operational levels
- Support with serious incident management and assessment of harm-related incidents. This includes CCG active involvement as part of internal rapid reviews and Trust incident review meetings, in addition to establishing an independent system panel to review incidents through the LMNS

- Support with emergency planning and seeking mutual aid
- Establishing a system oversight framework (see Appendix C) to monitor progress of both immediate safety plus the transformation and change programme. This includes establishing the NUH Maternity Safety Oversight and Quality Assurance Group (QAG) co-chaired by the CCG Accountable Officer and NHSEI Regional Chief Nurse (Midlands). The group aims to provide oversight and support for the NUH Maternity Improvement Programme. Representation includes Healthwatch, Professional Bodies, Health Education England, Regional Chief Midwife, Care Quality Commission (CQC), and Local Authority Public Health.

2.2 The CCG continues to work closely with Nottingham University Hospitals NHS Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge to the Trust's maternity improvement plans.

2.3 Working with LMNS partners the CCG has put in place a robust assurance process to track progress against required actions, increased scrutiny of untoward events and serious incidents at the Trust, and worked with the Trust to retrospectively review a number of maternity incidents

2.4 The CCG has worked with LMNS partners and NUH to respond to the findings and recommendations of the Ockenden report and taken steps to ensure the implementation of rapid safety changes within the Trust.

2.5 Working with the Maternity Voices Partnership and NUH the CCG has worked to make rapid improvement to maternity care and ensure the voice of the women and families is reflected in the Trusts' improvement plan. We know that listening to the stories of women and their families is an essential step in improving maternity services and we are committed to ensuring that happens.

2.6 A revised service specification is currently being drafted with an expected completion date of October 2021

2.7 A programme of Quality and Safety Insights visits was established in May 2021 where CCG and system partners including NHSE/I attended the Maternity service at NUH (across all areas). The purpose of these visits was to gain assurance about the quality and safety of services commissioned across Nottingham and Nottinghamshire. Though positive approaches to care was observed by the visiting team, and women and families reported kind and compassionate care, a number of areas of concern were identified. These included Infection Prevention and Control (IPC) practices, Medicines Management, availability of equipment (both essential and emergency), staffing and skill mix, communication and involvement, and a lack of learning culture. A number of immediate actions were identified.

2.8 Oversight and support was further strengthened through the creation of a CCG Head of Quality (Maternity) and Quality Manager (Maternity) posts.

2.9 The CCG has also worked with the LMNS and system partners to ensure oversight of the operational demands whilst responding to the COVID pandemic and roll out of both the

maternity COVID vaccination programme and COVID virtual wards. The LMNS PMO has coordinated a system approach to increasing uptake of the Covid vaccination for pregnant women, including a particular focus on clinically vulnerable pregnant women, on behalf of the vaccination cell. This multi-partner approach, including Maternity Voices Partnership, has resulted in agreed system communications as part of the every contact counts approach, vaccination clinics collocated with antenatal clinics, online webinars for women and families to access factual, clinically-led information and the development of a staff training package to support midwifery staff to have conversations with women who are vaccine hesitant.

2.10 This is not an exhaustive list however provides some insight into the numerous actions taken by the CCG to oversee and support the necessary improvements so babies, women and their families get the safe, effective and personalised care that they deserve.

3. Nottingham University Hospitals NHS Trust – Maternity Improvement Progress

3.1 Since January 2021 NUH have provided monthly progress updates to the QAG however concerns persist due to the lack of pace and assurance seen across the NUH Maternity Improvement Programme and a lack of focus on impact and outcomes.

3.2 Although considerable work to develop a meaningful Improvement Plan and a Provider Maternity Dashboard there is still not clear triangulation between these or the challenges the service faces.

3.3 Progress has been hindered by the change in critical leadership roles such as 4 Director of Midwife's and 3 Chief Nurse's in 8 months as well as the on-going operational demands.

4. NUH Maternity Improvement – CCG/ICS Upcoming Actions

4.1 Enhanced surveillance and system/regulatory support continues to be in place at Nottingham University Hospitals as part of Maternity Safety Oversight and Quality Assurance.

4.2 In addition to the established quality and safety oversight framework daily active assurance continues with CCG representatives present at daily Maternity MDT Safety Call, Maternity Divisional Case Review Meetings, Daily Rapid Reviews Meetings and Trust Incident Review Meetings.

4.3 A system-wide response and support offer is in place to address the on-going challenges at NUH with maternity governance, systems and procedures

4.4 Another Quality & Safety Insight Visit is scheduled for 28 and 29 September 2021 and key lines of enquiry have been developed based upon the initial visits, the maternity improvement plan and available system intelligence (including serious incidents).

4.5 NUH received £2,716,293 in NHSEI BirthRate+® funding (Sherwood Forest Hospitals (SFH) received £171,677). Plans to address the current NUH midwifery gap of 73WTE and 12 consultants are ongoing and will be reviewed through the NUH Maternity Safety Oversight and Quality Assurance Group and ICS workforce forums.

4.6 Continue support across the system due to recent operational demand & challenges:

- Progress Mutual Aid offers including access to the Improving Access to Psychological Therapies (IAPT) services, Let's Talk –Wellbeing with new processes in place to provide rapid access for families affected by NUH maternity services
- Support the review of planned/elective activity
- LMNS support to maximise vaccination uptake; vaccination hesitancy remains a local and national challenge
- Support with Quality Impact Assessment of Home Birth Services
- Regional input from NHSEI and Neonatal Network

Independent Review of NUH Maternity Services

4.7 On 10 September 2021 an update was shared with partners to inform of an *Independent Review of NUH Maternity Services* jointly commissioned by the CCG and NHSEI Midlands Regional team

4.8 The aim of this Review, which is due to commence October 2021, is to drive rapid improvements to maternity services in Nottingham by focussing on issues where change is urgently needed. The Review will analyse a broad range of information from complaints, incidents, concerns and family experiences, but will also have a clear focus on current practice to ensure that the appropriate standards of safety and quality are being delivered.

4.9 Initial thinking is that the review will need to draw on a large body of existing evidence: serious incidents, Healthcare Safety Investigation Bureau (HSIB) referrals, incidents internally recorded by the Trust, all coronial cases and relevant Preventing Future Death reports, number and types of litigations raised, complaints and concerns, cases of maternity admission to intensive care, maternity cases resulting in a referral to the GMC/NMC, workforce (vacancies and turnover), findings of cultural and staff surveys, data and information, and committee papers.

4.10 Critically, we want to make sure that we listen to and acknowledge areas of concern, and that these are put right, so that services are safe and provide high quality care for future families.

4.11 The Review will be completely independent of NUH, includes involvement from families and the findings and report will be made public when complete.

Involvement of Families

4.12 The Review will engage with families and is actively seeking membership of the proposed Reference Panel to support the work of the Review as it commences and throughout. It

is intended to share the draft Terms of Reference with families (as outlined below) shortly. We are committed to ensuring that affected families will be kept up to date and involved (in whatever way they wish) throughout the review. This will include membership and engagement in the Reference Panel and a written monthly update to all families and interested parties.

4.13 In addition to this, we will ensure that any concern raised through the Review by families is given full attention and unless already completed that these are thoroughly investigated through an Independent Investigation processes.

4.14 We have met with the legal representative of a considerable number of families and have further meetings arranged with several families and local and regional Maternity Voices Partnership Chairs to shape the Terms of Reference. Additionally, families who have contacted us but do not want to meet are providing written feedback on these ToR.

Key Personnel

4.15 A Programme Director has been appointed to support the independent Review team, who has the appropriate skills, experience and qualifications to undertake the work required and demonstrates clear independence from NUH.

4.16 Programme Director: Catherine Purt. Extensive NHS experience in commissioning, acute hospitals and primary care as well as private sector roles. Majority of experience in the North West of England but also across the South West and West, currently Non-Executive Director, Shropshire Community Health NHS Trust.

4.17 Over the coming week the appointment of two clinical leaders for the Review team will also be finalised and we will share their details.

Terms of Reference

4.18 A draft set of Terms of Reference (ToR) has now been drawn up and during September shared with affected families for their comments and input. A final version of this ToR is therefore anticipated to be produced at the start of October and will be published shortly afterwards. The ToR will describe the overall approach of the Review, its operating model, the areas of focus, how the families will be involved, its timescale and how the findings will be published. This ToR will be provided to the committee as soon as available.

4.19 The Review itself will commence its work at the beginning of October.

APPENDIX A - KEY SYSTEM ROLES & FUNCTION

Local Maternity & Neonatal System (LMNS): The LMNS is a partnership collaborative established to oversee the development and implementation of a local vision for transforming maternity services based on the principles of Better Births, the NHS Long Term Plan, the National Neonatal Review (Better Newborn Care), and the interim Ockenden Report.

The LMNS was established in 2017 following the publication of Better Births (2016) which set out the vision that through transformation, all maternity services across England will become safer, more personalised, kinder, professional, and more family friendly. A refreshed local Maternity Transformation Plan developed by the LMNS outlines the shared vision to ensure that women and their babies have access to consistently high-quality and safe services. This includes a commitment to move from operating within a traditional service-specific approach to outcome-focused commissioning.

On behalf of the Nottingham & Nottinghamshire Integrated Care System **LMNS Programme Management Office (PMO)** hosted by the CCG oversees the development and progress of evolving delivery plans to take forward priorities and ambitions.

The **LMNS Executive Partnership Board** seeks to obtain assurance that plans are progressing at a local level ensuring that transformation remains person centred to address the national priorities and trajectories for:

- Personalised Care
- Continuity of Care
- Safer Care
- Better Postnatal and Perinatal
- Mental Health
- Multi-Professional Working
- Working across Boundaries
- Payment System

Clinical Commissioning Group (CCG): As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services, the CCG plays an integral role to ensure we get the best maternity care and outcomes for our local families. The CCG is a key partner of the LMNS and the CCG/ICS Chief Nurse is the Senior Responsible Officer (SRO) for Maternity Transformation.

The **Maternity Voices Partnership (MVP)** is an NHS working group of maternity service users and system partner organisation including Healthwatch and 3rd sector.

LMNS Partner Organisations involved in developing and delivering maternity improvement and transformation:

Representing service users	Healthwatch Nottingham City and Healthwatch Nottinghamshire
	Nottinghamshire Maternity Voices Partnership
	Small Steps Big Changes (led by Nottingham CityCare Partnership)
Maternity and neonatal service providers	Nottingham University Hospitals NHS Trust
	Sherwood Forest Hospitals NHS Foundation Trust
Public Health and early years providers	Child Health Information Service (CHIS), Nottinghamshire Healthcare NHS Trust (county) and Nottingham CityCare Partnership (city)
	Children's centres: Nottinghamshire Childrenn and Families Partnership (county) and Nottingham City Council (city)
	Public health nursing: Healthy Families Programme, Nottinghamshire Healthcare NHS Foundation Trust (county)
	Small Steps Big Changes (led by Nottingham CityCare Partnership and funded by Big Lotto)
	Weight management: ChangePoint, Everyone Health
	Smoking cessation: Smokefree Lives Nottinghamshire, Solutions for Health (county), New Leaf, Nottingham CityCare Partnership (city)
Mental health providers	Insight Healthcare (psychology therapy)
	Nottinghamshire Healthcare NHSFT (mother and baby unit, perinatal psychiatry service, psychological therapy, child & adolescent)
	Trent PTS (psychology therapy)
	Turning Point (psychology therapy)
Other key providers	East Midlands Ambulance Service
	General Practice
	NHS 111 Service
	Social care (adult and children)
Commisssioners	Nottingham and Nottinghamshire CCGs
	Nottinghamshire Children's Integrated Commissioning Hub
	Nottinghamshire County Council
	Pubic Health England

Immediate and Essential Action

Better Births
Nottingham and Nottinghamshire
NHS

In December 2020, a review into maternity services was published by Senior Midwife Donna Ockenden and a team of leading health care professionals. The report had seven immediate and essential actions that NHS Trusts needed to follow. Here are some of the ways we are working together to provide the best maternity care possible for women and their families across Nottingham and Nottinghamshire.

1 Enhanced Safety

What we need to do:

Neighbouring Trusts must work together to make sure that investigations into serious maternity incidents (SIs) are looked into by local and regional maternity teams.

Our plan:

- We have set up a system working group to review and learn from serious incidents.
- Our Local Maternity and Neonatal System (LMNS) Board will have oversight of safety and learning from serious incidents will be shared across our local NHS organisations to make services safer.

2 Listening to Women and Families

What we need to do:

Maternity services must make sure that women and their families are listened to with their voices heard.

Our plan:

- We are working closely with our Maternity Voices Partnership (MVP) to involve women and families in planning and decisions about their care.
- We are working with local partners to make sure services involve fathers and partners in discussions about appointments and care.

3 Staff Training and Working Together

What we need to do:

Staff who work together must train together

Our plan:

- We will make sure staff have the right skills needed to safely care for women and thier families.

4 Managing Complex Pregnancy

What we need to do:

Make sure there are processes in place to help manage and support women with complex pregnancies

Our plan:

- Trusts have developed ways to help support women with complex pregnancies and will continue to review this.
- We are working with neonatal services to make sure women are able to give birth in the setting that is safest for them and their babies.

5 Risk Assessment Throughout Pregnancy

What we need to do:

Staff must make sure women have a risk assessment at each contact throughout their pregnancy.

Our plan:

- Midwives will continue to support women to make the right choice for them about where they want to have their baby.
- We are working together with women and their families to plan their care based on their needs.

6 Monitoring Fetal Wellbeing

What we need to do:

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with expertise to focus and show best practice in fetal monitoring.

Our plan:

- Trusts will have Midwife and Consultant Fetal Monitoring leads to improve practice, share learning and support staff with fetal wellbeing monitoring.

7 Informed Consent

What we need to do:

All Trusts must make sure women have access to accurate information so they can make choices about where they want to give birth and the mode of birth, including maternal choice for caesareans.

Our plan:

- Trusts will continue to update their websites to provide women and families with information about places of birth and how they will receive care, with printed and translated information also available.
- Trusts will work with the MVP and other partners make sure information is easy to find and suitable.

APPENDIX C - NUH MATERNITY QUALITY & SAFETY ASSURANCE ACTIONS

NUH Maternity Quality and Safety Assurance Actions

Local Maternity and Neonatal System (LMNS)

Active assurance and safety oversight

- All of these actions are overlapping and complimentary with mechanisms for sharing information and intelligence

Local Maternity and Neonatal System Executive Partnership Board
- multi-organisation stakeholder group
- established to oversee thedevelopment and implementation of a local vision for transforming maternity services
- specific focus on reducing health inequalities

NUH Maternity Safety Oversight & Quality Assurance Group (QAG) – established as part of Enhanced Surveillance
- Monthly multi-organisation single focus (NUH Maternity) quality assurance group co-chaired by CCG Accountable Officer & NHSEI Regional Cheif Nurse
- Allows oversight and support from wider regional and national partners including; Healthwatch, Professional bodies, Education and Training, National Midwifery Leaders, HSIB, CQC, Local Authority, Public Health

LMNS Safer Care and Outcomes Quality Group
- support LMNS oversight and assurance though the Perinatal Surveillance Model

NUH Internal Weekly Programme Oversight and Maternity QIP
- Maternity Transformation DirectoR
- Fortnightly CCG meetings with NUH to review and confirm/challenge

CCG overview of NUH Maternity Safe Today
- Weekly CCG /NUH CNO meetings
- Fortnightly CCG /NUH DoM/ DDON meetings

CQC
- CQC & NUH fortnightly meeting
- CQC & CCG monthly meetings

LMNS Serious Incident Shared Governance Group
- multi-organisational SI review panel integral to system SI investigation and learning process

LMNS Dashboard Sub Group
- multi-organisational Group supporting the collection, iterpretation & monitoring of system outcome data to inform improvement work

NUH Safe Today
- Documentation of NICE Red Flags, Acuity/Staffing, and Local Safety Indicators (twice/daily)
- Daily MDT Safety calls with attendance across Midwifery/ Obstetrics/ Neonatology/ Anaesthetists and CCG representatives

CCG Active Assurance
- CCG Head of Quality (Maternity) initially embedded within NUH now providing daily support
- CCG attendance at daily MDT Safety Calls, Divisional Incident Review Meetings and rapid case reviews-
- Programme of Quality Visits

NHSE/I Active Assurance
- Support to DoM/HOM
- Quality Improvement visits and partners
- Links into national and regional support/resource offers
- Governance Review
- Support in managing activity

Maternity Voices Partnership
- NHS working group of maternity service users and system partner organisation including Healthwatch and 3rd sector
- Active engagement
- NUH updating the MVP Board on the progress of the Improvement Plan

Overview of NUH Maternity Safe Today
-NUH Executive Review
-NUH Monthly Summary Reports share via CQC return

NHSEI & CCG
- Weekly Meetings established with Regional Head of Midwifery

KEY

LMNS Led | CQC Led | Sevice user Led | NHSE/I Led | CCG Led | NUH Led

Health and Adult Social Care Scrutiny Committee
11 November 2021

GP Services

Report of the Head of Legal and Governance

1 Purpose

1.1 To review GP provision and access across the City.

2 Action required

2.1 The Committee is asked to identify if any further scrutiny is required and, if so, the focus and timescales.

3 Background information

3.1 In recognition of the importance of access to high quality primary care in supporting the achievement of improved health outcomes and reduced health inequalities, the Committee has periodically reviewed aspects of the commissioning, delivery and access to GP services in the City. Over the last few years that have been a number of influences that have affected this, ranging from the strategic drivers of the NHS Long Term Plan, and changes to local commissioning arrangements to the Covid pandemic, which has impacted on access to care, particularly for face-to-face appointments. The Committee is aware that earlier this year Healthwatch Nottingham and Nottinghamshire published a report about GP access during Covid 19, which highlighted a number of issues around access locally. The Committee is also aware of a number of changes to different GP practices in the City over the last year. Therefore, the Committee decided to take a strategic look at current GP provision and access across the City, and the role of commissioners in ensuring access to high quality primary care for all.

3.2 Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has delegated commissioning arrangements for primary medical services from NHS England. This means that the CCG has full responsibility for the commissioning of general practice services, on behalf of NHS England.

3.3 A paper from the CCG is attached providing information on access to primary care in the City. The CCG's Associate Director of Primary Care will be attending the meeting to answer questions from the Committee. The Committee will want to use this information to consider whether it is satisfied with the current position or if further scrutiny is required, and if so the focus for that scrutiny.

4 List of attached information

4.1 ‘Access to Primary Care’ paper from Nottingham and Nottinghamshire Clinical Commissioning Group

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Healthwatch Nottingham and Nottinghamshire (March 2021) ‘GP access during Covid-19: A review of our evidence April 2019 – December 2020’

6.2 NHS Long Term Plan (January 2019)

7 Wards affected

7.1 All

8 Contact information

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Nottingham City Health Scrutiny Committee

Meeting 11 November 2021

Access to Primary Care

Dear Colleagues,

Nottingham City Council Health Scrutiny Committee have asked NHS Nottingham and Nottinghamshire CCG to provide an update for Members at the November 2021 meeting in relation to:

- Access to Primary Care

The brief below provides the update requested.

Joe Lunn

Associate Director of Primary Care

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Nottingham City Council Health Scrutiny Committee – Access to Primary Care

1. Introduction

Across Nottingham and Nottinghamshire CCG there are 124 GP practices, and these vary from single handed practices to large practices with multiple branch sites.

This brief is to provide the Nottingham City Council Health Scrutiny Committee with a background to primary care contracts and access to primary care services. This paper covers primary care contracts, the quality outcomes framework, enhanced services, workforce, access, regulatory/monitoring and GP survey results.

2. Contract

Contracts to deliver primary care services are offered using three different contract types:

General Medical Services (GMS) contract: The GMS contract is the national standard GP contract and is negotiated nationally between NHS England and the British Medical Association (BMA). GMS contracts can only be held by a partnership and at least one partner must be a general medical practitioner.

Personal Medical Services (PMS) contract: PMS contracts offered local flexibility compared to the nationally negotiated GMS contract but the historical financial premium attached to a PMS contract has now been eroded and GPs are moving to a GMS contract.

Both the GMS and PMS contracts are contracts in perpetuity i.e. the 'holders' of those contracts can continue as long as they wish and have control over who they add to that contract as additional partners.

Alternative Provider Medical Services (APMS): The APMS contract offers commissioners a route to procure primary medical services locally to meet the needs of the population. These contracts can be awarded to any provider and have a contract term, i.e. not a contract in perpetuity.

Practices receive a nationally negotiated price (global sum) for providing 'core primary care' on the basis of a £ per weighted[1] registered patient. The capitation fee is adjusted according to varying workload due to age, sex and patient need using the Carr-Hill formula to weight the patient list size. Further information about GP contracts is set out via the below link:

https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained

The global sum is £97.28 per weighted registered patient (April 2021).

The CCG has awarded 9 new APMS contracts over the last year and the value per weighted registered patient is higher than global sum for 7 of these contracts. This reflects the new contracts have a shorter contract term (not contracts in perpetuity). The contract values range from £97.28 (global sum) to £110.00 per weighted registered patient, in line with the procurements undertaken. The contract value will reduce annually and by year 5 will be in line with global sum. The APMS contracts are listed below:

[1] A 'Weighted' practice list is adjusted according to varying workload due to age, sex and deprivation for the registered population. A 'Raw' practice list is all patients registered at the practice and unweighted.

- Balderton Primary Care Centre
- Bilborough Medical Centre
- Broad Oak Medical Practice
- Grange Farm Medical Centre
- Kirkby Community Primary Care Centre
- Parliament Street Medical Centre
- Peacock Healthcare
- Southglade Medical Practice
- Whyburn Medical Practice

3. The Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a voluntary reward and incentive programme offered to every GP contractor. It affords increased payments to practices for the quality of care they provide to their patients and helps standardise improvements in the delivery of primary care. The QOF contains four main components, known as domains.

These are:

- Clinical
- Public Health
- Public Health – Additional Services
- Quality Improvement

The QOF is based on delivering a range of clinical targets, there is no specific target relating to access. Further information about QOF can be found via the below link:

https://www.england.nhs.uk/wp-content/uploads/2020/09/C0713-202021-General-Medical-Services-GMS-contract-Quality-and-Outcomes-Framework-QOF-Guidance.pdf

4. Enhanced Services

There are nationally and locally commissioned enhanced services which provide an extended range of services that practices can choose to provide, with an enhanced payment to the global sum. The Enhanced Services locally commissioned by Nottingham and Nottinghamshire CCG are:

- Enhanced Services Delivery Scheme (ESDS)
- Primary Care Monitoring of Amber 1 Shared Care Protocols and Patients with Stable Prostate Cancer
- Anticoagulation Monitoring Enhanced Service (Level 2, 3 & 4)
- Asylum Seekers, Syrian & Afghanistan Resettlement Programme
- Interpreter Assisted Appointments
- Homeless LES and Severe Multiple Disadvantage (SMD)
- Safeguarding Reports & Summaries
- Physical Health Checks for Patients with SMI

In 2019 a significant change occurred to GP contracts with the introduction of a new Directed Enhanced Service (DES) called the Network Contract DES, which is the basis for the Primary Care Networks. Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan, with practices being a part of a network. The networks provide the structure and funding for services to be developed locally, in response to the needs of the patients they serve. They benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services.

https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

Members' may wish to read Section 5, page 33, which sets out detail relating to going 'digital-first' and 'improving access'. This sets out intended improvements in relation to digital services and access and specific requirements include:

- Patient access to online records
- Patients' right to online and video consultation
- Ability to book appointments and order prescriptions online
- Provision of extended hours access (outside core contracted hours of 8:00am-6:30pm, Monday to Friday)
- Provision of GP appointments directly bookable by the 111 service

5. Workforce

Practices are contractually required to report workforce numbers monthly, this includes full-time equivalent (FTE) and headcount figures, with breakdowns of individual job roles. This is for the following staff groups: GPs, Nurses, Direct Patient Care (DPC), and Administrative staff.

Further information about the National Workforce Reporting System (NWRS) can be found via the below link:

https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services#summary

As independent businesses practices carry out their own recruitment to ensure delivery of services to their registered population, in accordance with the national contract.

The CCG has an established Primary Care Workforce Group who support practices to access national and local initiatives to attract, support and retain a workforce with the right skills to meet population health needs. This is achieved through increasing training numbers, reducing the attrition of qualified staff by keeping them in Nottinghamshire, offering attractive roles that allow work life balance, career and personal development as well as flexibility of portfolio - with senior practice staff supporting the next generation. The established Primary Care Training Hub supports the training and education of our workforce, embeds new roles and supports workforce planning.

The introduction of Primary Care Networks (PCNs) builds on core primary care services with an aim to improve the ability of general practice to recruit and retain staff by providing integrated health and care services to the local population. The recruitment of Additional Roles (ARs) staff e.g. Clinical Pharmacist, Physician Associate, Occupational Therapist, enables a greater provision of proactive, personalised care delivered by an increasing workforce with a diverse skill set. This creates a bespoke multi-disciplinary

team to ensure that individual patient needs are met by the most appropriate professional to support their care, in line with national policy to build a broader workforce in primary care.

Across Nottingham and Nottinghamshire CCG there are currently 226.8 WTE ARs staff in post.

6. Access

There has been a national initiative on improving access to general practice for the past five years, but this has focused principally on the development of extended hours access. Further information can be found via the below link:

https://www.england.nhs.uk/wp-content/uploads/2017/11/improving-access-general-practice-national-slidedeck.pdf

6.1. Practice appointment data

Practices have a contractual requirement to allow the extraction of anonymised and aggregated data about appointments offered.

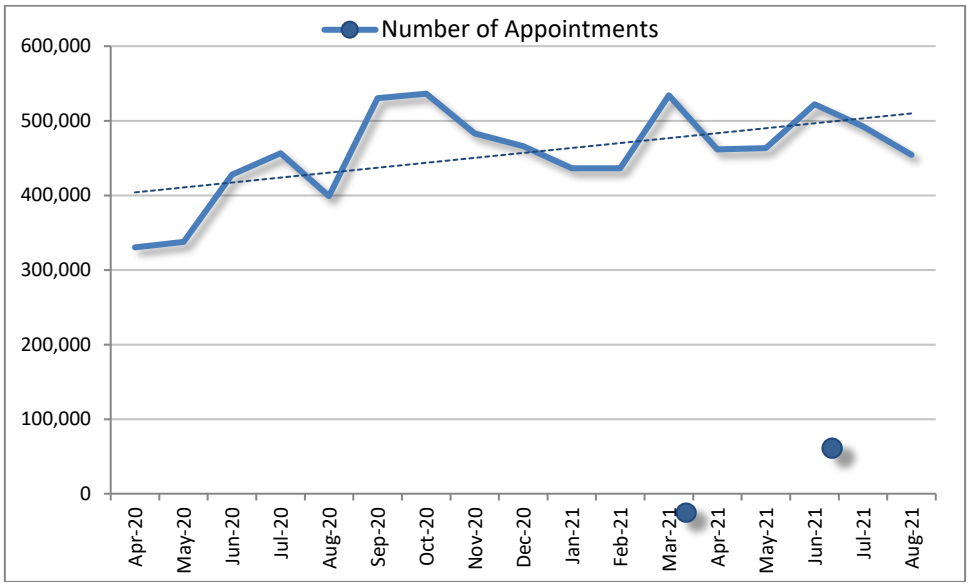
This appointment information is published by NHS Digital but only gives CCG aggregated data, not practice specific data. This can be viewed via the below link:

https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

The latest access data available is for August 2021. The figures for Nottingham and Nottinghamshire CCG are provided below (this table also shows data for August 2020 as a comparison):

	August 2021	*August 2020*
Number of appointments:	454,315	*399,056*
Appointment type:		
Face to face	263,103	*211,162*
Home visit	1,629	*1,328*
Telephone	164,427	*164,253*
Video/online	2,418	*1,984*
Unknown	22,738	*20,329*
From booking to appointment:		
Same Day	206,755	*182,822*
1 Day	29,227	*31,667*
2 to 7 Days	85,337	*81,754*
8 to 14 Days	56,688	*49,993*
15 to 21 Days	34,092	*24,158*
22 to 28 Days	22,084	*13,724*
More Than 28 Days	20,048	*14,854*

The graph below shows the number of appointments undertaken over the period April 2020 to August 2021. The graph shows a significant increase in September 2020 when lockdown restrictions eased. However, the introduction of a second lockdown shows a decrease in access from November 2020. The reduction in access for August 2021 reflects the traditional summer holiday period for the population, which is also shown in August 2020 (albeit during lockdown), the data shows an increase in access in comparison.



6.2. Booking appointments

The way patients book appointments changed as a result of COVID. During COVID face to face appointments were based on clinical need so triage and remote consultations became the primary way to see and treat patients. Returning to 'business as usual' practices are now offering more face to face appointments; practices do still operate a triage system but will arrange a face to face appointment where there is a clinical need. Data indicates that there has been an increase in the number of appointments provided by practices (higher demand than before COVID) and 50% of appointments are same day.

The CCG has received correspondences from local MPs and Councillors stating that access continues to be a concern with their constituents, particularly the ability to secure a face to face consultation. August 2021 access data for England shows that practices carried out 25.5 million recorded patient appointments in August 2021, including 1 million more non-vaccination appointments compared with August 2019.

7. Monitoring

The CCG does not routinely monitor the number of appointments offered or the average waiting time for an appointment as there is no contractual requirement to offer an appointment in a specific amount of time. However, patients' views on access to GP appointments are captured annually via the national GP Patient survey. The latest results were published on 8 July and are available via the below link:

https://www.england.nhs.uk/statistics/2021/07/08/gp-patient-survey-2021

It is possible to view and compare practice level data. In terms of access data, the Nottingham and Nottinghamshire CCG results are higher overall than the national average but there is variation between practices:

GP Survey Results 2021

	CCG Average	National Average	Highest Practice	Lowest Practice
How easy is it to get through to someone at your GP practice on the phone	72%	68%	98%	21%
How often do you see or speak to your preferred GP when you would like to	45%	45%	85%	7%
How would you describe your experience of making an appointment	73%	70%	95%	28%
How would you describe your experience of your GP practice	84%	83%	99%	55%

Practices are monitored using multiple sources of information to ensure they are delivering their contractual requirements and providing high quality services to their patient population.

Whilst practices have a GMS, PMS or APMS contract the CCG also has a Primary Care Quality Dashboard, which includes the following information for each practice:

- CQC: rating for each domain (safe, effective, caring, responsiveness, well-led) and overall rating
- Clinical outcomes: immunisations, flu vaccinations, screening
- Patient experience: friends & family test, national survey, patient feedback, health checks, and registers
- Patient safety: safeguarding, policies and named leads

This information is regularly monitored by the CCG Primary Care Commissioning Team and the Primary Care Quality Team at monthly and quarterly review meetings. The dashboard uses a RAG (red, amber, green) system. If a practice is rated amber or red a meeting is organised with the practice to consider the challenges the practice has and how the CCG can support the practice. This process takes into consideration a number of other factors, for example, challenges with workforce (recruitment, retention, and retirements), the estate (capacity, condition, compliance) etc.

Nottingham and Nottinghamshire ICS also conducted a piece of public research with residents to understand their experience of care during the pandemic including how they feel about appointments being conducted remotely.

This is accessible here: https://healthandcarenotts.co.uk/listening-to-our-citizens-and-patients-during-the-coronavirus-pandemic/

8. Regulatory Roles and Assurance

NHS England is responsible for high quality primary care services for the population of England. Nottingham and Nottinghamshire CCG has delegated commissioning arrangements for primary medical services. This means the CCG has full responsibility for the commissioning of general practice services for the local population, on behalf of NHS England.

NHS England retains responsibility for commissioning dental, optometry and community pharmacy services.

Other organisations have a role in monitoring primary care, as follows:

8.1. Care Quality Commission

Practices are regularly reviewed by the independent regulator, the Care Quality Commission (CQC). One of their five Key Lines of Enquiry concerns responsiveness and, in particular, access to appointments:

https://www.cqc.org.uk/help-advice/what-expect-good-care-services/what-can-you-expect-good-gp-practice

All practices are inspected by CQC and following a visit a report is published which includes a rating for each of the Key Lines of Enquiry and an overall rating for the practice (Outstanding, Good, Requires improvement, or Inadequate).

8.2. Healthwatch

Healthwatch is an independent organisation to ensure that people's voices are heard and they are involved in decisions that affect them. Healthwatch takes a keen and independent interest in access to GP services

https://hwnn.co.uk/gp-access-review-must-be-part-of-nhs-covid-19-recovery/

The Healthwatch report highlights a major concern at the present time, which is that the move to remote consultations necessitated by the pandemic has not suited all patients, with a higher number of patients expressing dissatisfaction with GP services compared with pre-pandemic. Practices have been 'opening up' and offering more face to face appointments but are having to do so at the same time as mitigating the ongoing risks of COVID infection (see below).

9. Summary

The CCG is responsible for commissioning general practice medical services, on behalf of NHS England, and monitors delivery of services through the nationally negotiated GP contract.

Practices have a contractual requirement to report their workforce numbers monthly via the National Workforce Reporting System (NWRS). Recruitment remains challenging in primary care, further compounded by the COVID outbreak. The CCG uses national and local initiatives to support a range of recruitment and retention schemes and training to core clinical delivery.

The GP Survey questions included in this paper are good indicators of patient satisfaction showing that the CCG average score is higher than the national average score. However, the GP Survey results published July 2021 are only one indicator of patient satisfaction. Practices obtain feedback from the Friends and Family Test (paused nationally during COVID), and through their own feedback mechanisms. Nottingham and Nottinghamshire CCG has a registered population of circa. 1.1 million, the maximum number of responses for a GP survey question was 15,500 which is 1.4% of the registered population.

There are no specific contractual requirements in relation to the levels of access for primary care services, however access and quality is monitored through both national and local platforms. Patient reporting of difficulties in accessing services (particularly during the pandemic) isn't unique to Nottingham and Nottinghamshire, this has increased for practices across England.

NHS England published guidance on 14 October 2021; 'Our plan for improving access for patients and supporting general practice' which set out details of support to practices to help improve access and specifically face to face appointments over the winter period. Initial plans were submitted to NHS England regional colleagues on 28 October 2021.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf

PCNs are leading the work of appointing and supporting Additional Roles staff to work in general practice to supplement the work of practice GPs and nurses, further improving access. This supports the key role for practices in ensuring that patients access the right care, in the right place and at the right time. This means that practices are providing services utilising a range of multi-disciplinary professionals to best meet the needs of individual patients, in line with national policy to build a broader workforce in primary care.

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Health and Adult Social Care Scrutiny Committee
11 November 2021

Proposed changes to Neonatal Services

Report of the Head of Legal and Governance

1 Purpose

1.1 To consider proposals for changes to neonatal services provided by Nottingham University Hospitals NHS Trust.

2 Action required

2.1 The Committee is asked to consider proposed changes to neonatal services provided by Nottingham University Hospitals NHS Trust and decide whether:

a) it agrees with the assessment of Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) that the proposals do not constitute a substantial variation or development of service and decide if:
   i. it is satisfied with the proposals as outlined in the attached paper; or
   ii. further information and/or scrutiny is required and, if so, the focus and timescales for this; or
   iii. it wishes to make comment or recommendation to the CCG about the proposals

or

b) it considers that the proposals do constitute a substantial variation or development of service and determine how it wishes to proceed.

3 Background information

3.1 Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has advised the Committee of proposals for change to neonatal services provided by Nottingham University Hospitals NHS Trust. The CCG considers that the proposals will have significant benefits for affected families but that numerically the development represents an adjustment to a clinical pathway rather than a major service redesign.

3.2 The CCG has submitted a written paper to the Committee outlining details of the proposed changes, the context and case for change and proposals for engagement. This paper is attached. In agreement with the Chair, this is a written paper only for the Committee's consideration and no one from the CCG will be attending the meeting. Any questions or issues arising from the paper will be directed to the CCG following the meeting for response.

3.3 In considering the proposals, the Committee will want to consider whether it agrees with the CCG's assessment that the proposals do not constitute a substantial variation or development of service. If this is the case, the Committee can still consider proposals and make comment or recommendation as appropriate. If the Committee does take the view that the proposals are a substantial development or variation, then this will need to be discussed further with commissioners.

4 List of attached information

4.1 'Case for change for expansion of neonatal capacity at Nottingham University Hospitals' paper from Nottingham and Nottinghamshire Clinical Commissioning Group

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 None

7 Wards affected

7.1 All

8 Contact information

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Nottingham City Council Health Scrutiny Committee

Case for Change for Expansion of Neonatal Capacity at Nottingham University Hospitals

1. Overview and Summary of Proposal

Nottingham University Hospitals are proposing to access NHS capital funds to increase the number of neonatal cots at the Queens Medical Centre (QMC) from 17 to 38. It is planned that this development is completed by 2023.

Current Neonatal Configuration in Nottingham

At the QMC campus there are currently 17 cots (11 Intensive care/high dependency and six special care) along with six transitional care cots on the postnatal ward (C29) which are co-located with maternity services on B Floor of the East Block. Clinically adjacent to and supporting the Neonatal service is specialised paediatric surgery within Nottingham Children's Hospital and the other paediatric tertiary specialists.

At the City Hospital campus, there are 24 cots (12 Intensive care/high dependency, 12 special care) along with six transitional care cots. The Neonatal Unit is co-located with maternity services in the maternity building. There are no other children's inpatient services at the City Hospital, and there is limited access to specialised radiology. Babies requiring specialised imaging, surgical care or other sub-speciality input are currently transferred from the City to the QMC campus. From April 2019 to April 2020, there were 147 transfers between sites.

In the same period, 116 babies could not be accommodated on either Nottingham sites and had to be transferred to other units, not just in the East Midlands, but much further afield. Destinations for these babies in 2019 included Burnley, Luton, Scunthorpe, Bradford and Birmingham.

Total Additional Neonatal Cots required

In order to address all of the Neonatal capacity issues identified and meet future demand the following additional cots are required at the QMC:

- Activity sent out of network = 6 Cots
- Reducing the QMC Neonatal Unit occupancy to 80% = 5 cots
- Activity that could no longer take place at the City Hospital Neonatal Unit if it is re-designated as a Local Neonatal Unit = 10

This is a total of 21 additional cots increasing the total number at the QMC from 17 to 38. The overall impact is shown in the table below including the reduction at City and the overall increase for the system.

Cot Type	Current			Proposed (Change)		
	QMC	City	**Total**	QMC	City	**Total**
Intensive Care	6	6	**12**	13 (+7)	2 (-4)	**15 (+3)**
High Dependency	5	6	**11**	12 (+7)	2 (-4)	**14 (+3)**
Special Care	6	12	**18**	13 (+7)	12 (-)	**25 (+7)**
TOTAL	**17**	**24**	**41**	**38 (+21)**	**16 (-8)**	**54 (+13)**

2. National Context

National Neonatal Critical Care Transformation Review

The National Neonatal Critical Care Transformation Review (NCCR) was published in December 2019. It was structured across 5 key work areas; Capacity, Workforce, Pricing, Education and Models of Care.

The aim of the Review was to make recommendations that will support the delivery of high quality, safe, sustainable and equitable models of neonatal care across England. The proposal to expand neonatal capacity in Nottingham responds to the findings of this national review as follows:

Mortality

- Local Maternity Networks (LMNs) must ensure that, where possible, all women at less than 27 weeks gestation are able to give birth in centres with a Neonatal Intensive Care Unit (NICU)
- LMNs and Operational Delivery Networks (ODNs) should aim to ensure that at least 85% of all births at 23-26 weeks' gestation are in a maternity service with an on-site NICU

Neonatal Care Capacity

- Neonatal services should have the capacity to provide all neonatal care for at least 95% of babies requiring admission for neonatal intensive care, and born to women booked for delivery within the network (i.e. the target of 95% was set to allow for the occasional woman who gives birth whilst on holiday or visiting the area)
- Neonatal services should not operate above 80% occupancy averaged over the year
- Babies requiring neonatal services should receive that care from a unit with the appropriate level of care as close as possible to the family home

The Nottingham Neonatal Service does not currently have the capacity to fulfil its service specification and provide intensive care for all Nottingham-booked and North Hub East Midlands Network (EMN) ODN babies who require it. The Neonatal Unit at the QMC usually operates at a level that is on average greater than 95% occupancy far exceeding the 80% average occupancy prescribed.

Neonatal Unit Designation:

- All neonatal units designated as NICUs must provide more than 2,000 intensive care days per year.

The proposal to increase neonatal capacity in Nottingham in the short term needs to be seen in the context of the ambition of the New Hospital's Programme (Tomorrow's NUH) when – amongst other developments – it is proposed that Neonatal Services will be delivered on a single site. The clinical case shows beyond doubt that prolonging the current situation until such time as the larger scheme is delivered, is not a realistic option, given the mortality and morbidity impacts of not having sufficient Neonatal capacity in Nottingham, combined with the issues related to patient (and families') experience as described above.

The Neonatal service is small numerically in terms of patients, but is regionally commissioned, and the current capacity shortfalls have significant long term detrimental impacts on the babies, not just in the immediate period of care, but also going forward into childhood and indeed full maturity.

3. The Local Case for Change - Why is this Investment and Change Needed?

There are four key drivers for change for this proposal:

1. Insufficient capacity within the Nottingham Neonatal Service to meet local demand resulting in babies being sent out of network for their care. This has a serious impact on mortality and morbidity as highlighted in the December 2020 Getting it Right First Time (GIRFT) Report.
2. The need to respond to the NNCR Report and in particular the requirement for NICUs to provide more than 2,000 critical care cots days per year.
3. The environment and space available on the Neonatal unit at the QMC is not fit for purpose, leading to increased risk of cross-infection and mortality.
4. Insufficient obstetric theatre space with only one full sized obstetric theatre.

The NHS Outcomes Framework 2019/20 includes the following domains specific to Maternity and Neonatal Services:

- Preventing babies from dying prematurely
- Ensuring that people have a positive experience of care (women's experience of maternity services)
- Treating and caring for people in a safe environment and protecting them from avoidable harm

This proposal aligns with the NHS Outcomes Framework 2019/20 by creating a larger, neonatal intensive care service at QMC campus, supported by Special Care Baby Unit at City campus, which will improve outcomes for pre-term infants in terms of mortality, as the number of babies needing to be transferred out of area will be significantly reduce. Prematurity and congenital abnormalities are the single largest causes of deaths among babies less than one year in age. Also, the proposal aims to improve families' experience of neonatal intensive care by ensuring they are cared for in a safe suitable environment, again aligning to the NHS Outcomes Framework.

The Getting It Right First Time (GIRFT) report identified serious concerns in the EMN ODN as follows:

- Major capacity issues in the three NICUs (two in Nottingham and one in Leicester) are causing excess deaths and poorer quality of care for babies in the EMN ODN.
- The proportion of high-risk babies (extremely premature babies and babies requiring intensive care) dying in local neonatal units and special care baby units in the first week of life is more than twice the national average and is higher than any other network.
- The mortality rates in the NICUs in EMN ODN are low/ average (i.e. NICU performance is not an issue)
- Critically unwell babies are not being transferred from Local Neonatal Units (LNUs) and Special Care Units (SCUs), due to lack of capacity in the NICUs

The GIRFT report also cited serious concerns regarding capacity at Nottingham, including that the capacity gap is the greatest in any NICU nationally. Local data from NUH shows that:

- Occupancy levels across all cot types at the QMC are the highest in the country at nearly 100%. Combined special and transitional care cots at the QMC are insufficient for the number of live births (lowest decile) and special care occupancy is consequently well above recommended levels at nearly 125%.
- Total cot occupancy at City is just under the recommended 80% with special care cot occupancy greater than 80%.
- Capacity transfers for non-clinical reasons are five times higher than the NICU average for the QMC, and in the upper quartile at City.

- Both hospitals are in the lowest performing decile in relation to the percentage of pre-term infants born in the NICU
- There are significant numbers of 'out born' babies who need to be transferred back into the NICU having received care out of network

Patient/Family Experience

Whilst the clinical benefits to the families of neonates in terms of the significant reduction in the risk of pre-term babies being transferred out of Nottingham (as well as the improved environment in the new, expanded unit) are clear, there are other practical considerations in relation to access, travel and car parking.

Commissioners will work closely with NUH to ensure that for those families who will in future be able to access this expanded local NICU capacity, access and travel concerns are addressed during in-patient and subsequent family visiting periods. We will also analyse feedback from families who have used the current service, some of whom will have seen first-hand the shortfall in resource, and the consequence of having neonatal care provided far from home.

4. Conclusions

This is a major quality improvement for a small number of pre-term babies and their families. The expansion of neonatal intensive care cots at QMC campus will reduce significantly the number of babies needing to be transferred to other hospitals, and the realignment of neonatal care between City and QMC will provide better resources – numbers of staff, expertise, equipment and physical space – for those patients. By way of context the total births at NUH per annum is. circa 8500, albeit that this key clinical development will only apply to approximately 250 babies. The benefits to these families are significant but numerically this development represents an adjustment to a clinical pathway rather than a major service redesign.

Commissioners will work alongside NUH to engage widely with citizens who will access services at both QMC and City to ensure that the development meets user requirements.

The proposed targeted engagement approach comprises three main strands:

1. Review of existing patient experience data. Working with NUH and the CCG Quality team, available patient experience data covering the period of April 2019 to date will be collated and analysed, with a focus on understanding both positive and negative experiences of individuals who have accessed Neonatal services at both QMC and City. Existing research/engagement publications in this area will also be scoped and reviewed to provide a broad evidence base for change.
2. Engagement with patients. This will be focused on previous/current service use, the proposed change and asking for feedback. Methods will include an online survey and/or paper survey, which will include questions about previous/current use of the service, what went well, and what could be improved. There will also be the opportunity to take part in focus groups and workshops to allow patients to provide detailed information about their experiences. Working in partnership with NUH, the Nottingham and Nottinghamshire Maternity Voices Partnership, the CCG's Patient and Public Engagement Committee, Healthwatch Nottingham and Nottinghamshire and other relevant community groups (including organisations such as Zephyr's) will ensure that the voices of those who may be disproportionately impacted are heard, and that the engagement exercise reaches the right people.
3. Ongoing patient and public assurance. The survey, its responses and a "You Said, We Did" summary will be published on the CCG website and disseminated through partners engagement channels.

Commissioners and providers are keen to proceed expeditiously to access the capital funding available to support this major development for Nottingham and Nottinghamshire

To this end, the CCG wishes to consult with the Health Scrutiny Committee on this proposal, and in parallel, approval is requested from the Health Scrutiny Committee to proceed with a targeted engagement approach (rather than public consultation), the findings of which will be reported back as required. The consideration of the decision to proceed with this work is imminent and therefore a formal response to this request is required before 25th November 2021.

Lucy Dadge
Chief Commissioning Officer
NHS Nottingham and Nottinghamshire CCG

Appendix – Key Drivers

Insufficient capacity within the Nottingham Neonatal Service to meet local demand:

- The Nottingham Neonatal Service does not have sufficient capacity to provide care for all of the sickest and most vulnerable babies it is expected to care for. An average of 116 babies per year (average for 2018-2020) was transferred out of Nottingham and to elsewhere in the UK for their care (in-utero and ex-utero). This has a significant impact on outcomes (as demonstrated within the recent GIRFT report) and detrimentally impacts upon parents and families.
- The GIRFT report showed that the Nottingham Neonatal Unit has the most serious capacity issues of any NICU nationally, and this is having a demonstrably negative impact on both quality of care and mortality for high risk babies born elsewhere in the network who are unable to access the service when they need it. The capacity gap is very significant, and there is currently no agreed plan to resolve this issue which the MNRr business case being put forward seeks to address. Of particular concern within the GIRFT report are:
    - Occupancy levels across all cot types at the QMC which are the highest in the country at nearly 100%.
    - Capacity transfers for non-clinical reasons are five times higher than the NICU average for the QMC, and in the upper quartile at City
    - There are significant numbers of 'out born' babies who need to be transferred back into the NICU having received care out of network (this is the 116 babies noted above).
    - Transfers out of Nottingham affect surrounding neonatal and transport services, creating a ripple effect on hospitals throughout the UK as demand and capacity issues are passed on.
    - This is currently a risk score of 15 within the Family Health risk register (Datix reference: 5507).

The need to respond to the Neonatal Critical Care Transformation Review report:

- The NCCR sets some standards for Neonatal Units which are not currently achieved within the Nottingham Neonatal units. In particular:
    - All neonatal units designated as NICU must provide more than 2,000 intensive care days per year. The neonatal unit at the QMC does not consistently provide more than 2,000 intensive care days per year and the neonatal unit at the City Hospital does come close to meeting this threshold. As neither of the Nottingham neonatal unit currently meets the requirements to be designated a NICU there is a risk that they could both be re-designated as LNUs. If NICU status were lost and the units were both re-designated as LNUs, it is unlikely that neonatal surgery could continue at the QMC. Other important services would also be affected, such as supra-regional neonatal neurosurgery, some neonatal nephrology and foetal medicine services. This would have major consequences for Neonatal and Maternity Services in Nottingham.
    - Neonatal services should not operate above 80% occupancy averaged over the year. The Neonatal Unit at the QMC usually operates at a level that is on average greater than 95% occupancy far exceeding the 80% average occupancy prescribed.

The environment and space available on the Neonatal unit at the QMC is not fit for purpose, leading to increased risk of cross-infection and mortality.

- This impacts on the quality of care, infection control and patient, parent and staff experience.
- Lack of space is an incredibly significant risk for cross-infection between patients and the ultimate harm from this is death. There have been documented outbreaks on the neonatal units within the period 2016-2021 with documented evidence of harm in babies.
- Isolation of babies when an infection occurs is not possible due to lack of suitable spaces.
- Based on Health Building Note (HBN) regulations, the current space is 2-2.5 times too small per cot space.
- This risk is recorded on the Family Health risk register with a score of 20 (Datix reference: 9300).

Insufficient obstetric theatre space with only one full sized obstetric theatre

- Providing two complex cases simultaneous is difficult (is this due to the size of the theatre and or other reasons)? When looking at the performance of complex elective and emergency operations.
- The existing theatres will not be able to provide sufficient capacity to meet increased needs arising from an increase in Neonatal Activity at the QMC. Specific to the small theatre is the fact that any complex case involving a premature baby and a complex delivery will be difficult to manage in the small theatre with equipment and staff needed. Is there a clinical risk to mother and baby with the current size.

Based on the local, regional and national strategies, existing arrangements and the case for change, the investment objectives for this project are as follows:

- To redevelop the environment and space on the Neonatal Unit at the QMC and to be closer to national recommendations (HBN 09-03)
- To increase the NICU capacity on the QMC campus from 17 to 38 cots
- To improve the experience of the mothers and families of babies needing Neonatal Care
- To increase Obstetric theatre space and improve the Obstetric theatres environment at the QMC.
- To achieve balance of service configuration across Obstetric theatres, Obstetric beds and Neonatal

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Health and Adult Social Care Scrutiny Committee
11 November 2021

Work Programme

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the Committee's work programme for 2021/22 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

1.1 The Committee is asked to note the work that is currently planned for the remainder of the municipal year 2021/22 and make amendments to this programme as appropriate.

3. Background information

3.1 The purpose of the Health Scrutiny Committee is to act as a lever to improve the health of local people. The role includes:

- strengthening the voice of local people in decision making, through democratically elected councillors, to ensure that their needs and experiences are considered as part of the commissioning and delivery of health services;
- taking a strategic overview of the integration of health, including public health, and social care;
- proactively seeking information about the performance of local health services and challenging and testing information provided to it by health service commissioners and providers; and
- being part of the accountability of the whole health system and engaging with the commissioners and providers of health services and other relevant partners such as the Care Quality Commission and Healthwatch.

3.2 As well as the broad powers held by all overview and scrutiny committees, committees carrying out health scrutiny hold the following additional powers and rights:

- to review any matter relating to the planning, provision and operation of health services in the area;
- to require information from certain health bodies[1] about the planning, provision and operation of health services in the area;
- to require attendance at meetings from members and employees working in certain health bodies[1];
- to make reports and recommendations to clinical commissioning groups, NHS England and local authorities as commissioners of NHS and/or public health services about the planning, provision and operation of health services in the area, and expect a response within 28 days (they are not required to accept or implement recommendations);

[1] This applies to clinical commissioning groups; NHS England; local authorities as commissioners and/or providers of NHS or public health services; GP practices and other providers of primary care including pharmacists, opticians and dentists; and private, voluntary sector and third sector bodies commissioned to provide NHS or public health services.

- to be consulted by commissioners of NHS and public health services when there are proposals for substantial developments or variations to services, and to make comment on those proposals. (When providers are considering a substantial development or variation they need to inform commissioners so that they can comply with requirements to consult.)
- in certain circumstances, the power to refer decisions about substantial variations or developments in health services to the Secretary of State for Health.

3.3 While a 'substantial development or variation' of health services is not defined in legislation, a key feature is that there is a major change to services experienced by patients and/ or future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. Health scrutiny committees have statutory responsibilities in relation to substantial developments and variations in health services. These are to consider the following matters in relation to any substantial development or variation that impacts on those in receipt of services:

- whether, as a statutory body, the relevant overview and scrutiny committee has been properly consulted within the consultation process;
- whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
- whether the proposal for change is in the interests of the local health service.

Where there are concerns about proposals for substantial developments or variations in health services, scrutiny and the relevant health body should work together to try and resolve these locally if at all possible. Ultimately, if this is not possible and the committee concludes that consultation was not adequate or if it believes the proposals are not in the best interests of local health services then it can refer the decision to the Secretary of State for Health. This referral must be accompanied by an explanation of all steps taken locally to try and reach agreement in relation to the proposals.

3.4 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.5 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.6 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.7 The current work programme for the municipal year 2021/22 is attached at Appendix 1.

4. List of attached information

4.1 Appendix 1 – Health Scrutiny Committee Work Programme 2021/22

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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Health and Adult Social Care Scrutiny Committee 2021/22 Work Programme

Date	Items
13 May 2021	• **Terms of Reference** To note the terms of reference for the Committee • **Platform One** To assess progress towards the transition date of 1 July 2021, particularly in relation to vulnerable patients to be dispersed to local practices (to include reference to how the EQIA is evolving, being monitored and responded to) • **Nottinghamshire Healthcare NHS Foundation Trust Strategy** To consider the Trust's strategy in order to identify a focus for any further scrutiny of mental health issues in 2021/22 • **Work Programme 2021/22**
17 June 2021	• **Integration and Innovation White Paper** To consider the implications of proposed reforms to health and care and the potential local impact • **Integrated Care System: Community Care Transformation** To consider and comment on this ICS priority which will involve a review of all community services • **Quality Accounts 2020/21** To note the scrutiny comments on each Quality Account (if any submitted) • **Work Programme 2021/22**
15 July 2021	• **Maternity Services** To review the action taken by NUH over the last six months to improve maternity services • **Tomorrow's NUH**[1]

[1] Informal meeting held to do some deep dive consideration of the Tomorrow's NUH programme 30 June 2021 (Phil Britt, Nina Ennis, Lucy Dadge) focused on maternity and cancer services. A further deep dive meeting to be held later in the year to focus on outpatients' care and splitting elective/ emergency services.

Date	Items
	To consider progress to date and plans for consultation and engagement. • **Work Programme 2021/22**
16 September 2021	• **Assessment, Referrals and Waiting Lists for Psychological Support** To consider the Nottinghamshire Healthcare NHS Foundation Trust's plans for managing access to psychological support, particularly in relation to step 4 psychotherapy and psychological therapies. • **Reconfiguration of Acute Stroke Services** To consider proposals for making changes to the configuration of acute stroke services permanent. Changes were made on a temporary basis to support the response to the Covid pandemic. If it is proposed to make the changes permanent, then this is likely to be a substantial variation to services and the Committee will need to carry out its statutory role as a consultee • **Covid 19 Local Vaccination Programme** To assess progress with local delivery of the vaccination against national targets (at 23/03/21 the whole population should have had at least one dose by the end of July 2021) • **Work Programme 2021/22**
14 October 2021	• **Update on Elective Care Recovery** To scrutinise the impact of delays on elective care due to Covid 19, plans to mitigate this impact and the progress with meeting need following delays • **Eating Disorder Services** To assess the impact of expansion to workforce capacity to services, consider the continuing use of BMI as a threshold for access to services and to consider the impact of out of area adult inpatient placements. • **Work Programme 2021/22**
11 November 2021	• **Nottingham University Hospitals NHS Trust – CQC Inspection** To consider the findings of the recent CQC Inspection of NUH and scrutinise action being taken to address areas identified as inadequate and requiring improvement, with a particular focus on the

Date	Items
	Well-Led domain. • **GP Services** To review GP provision and access across the City • **Work Programme 2021/22**
16 December 2021	• **Draft Medium Term Financial Plan (MTFP) - Adult Social Care focus** To consider proposals relating to Adult Social Care in the draft MTFP (as part of the consultation on the MTFP) • **Transformation Programme Adults Portfolio** To receive an overview of the Adults Portfolio of the Council's Transformation Programme • **Platform One** To assess the initial impact of the transition to the new city centre practice and to local practices, with particular reference to the experiences of vulnerable patients. • **Work Programme 2021/22**
13 January 2022	• **Adult Social Care Workforce Development Plan** To review the draft Workforce Development Plan, which forms part of the Council's recovery and improvement activity • **Work Programme 2021/22**
17 February 2022	• **Nottingham University Hospitals NHS Trust Maternity Services** To review action being taken by NUH to improve maternity services following CQC rating of 'Inadequate' in December 2020 • **Provision of Services for Adults with Learning Disabilities** To review changes to provision for adults with learning disabilities • **Work Programme 2021/22**

Date	Items
17 March 2022	• **Work Programme 2021/22**
15 April 2022	• **Reconfiguration of Acute Stroke Services** To consider the proposals for making changes to the configuration of acute stroke services permanent, which is a substantial variation of services and therefore the Committee will need to carry out its statutory role as a consultee • **Work Programme 2022/23**

Items to be scheduled

It was agreed at the 13 May HSC meeting that some members would visit the new SMD LES once it is safe to do so, ie post pandemic (liaise with Joe Lunn, CCG)

Item	Focus
1. Discharge and after care (including impact on Social Care)	To consider the effectiveness, including the impact on adult social care, of current plans and practice for the discharge of patients from hospital care
2. NHS and National Rehabilitation Centre (NRC)	Update on the Decision Making Business Case and implementation plans
3. White Paper	To contribute to discussions about new arrangements, especially in relation to governance, representation on committees and engagement and consultation with the public about local changes
4. Community Care Transformation	CCG to keep HSC informed of progress at Chair/ Vice Chair and CCG monthly meetings.
5. Child and Adolescent Mental Health Services (CAMHS)	(a) To consider the services provided by CAMHS in the light of the need for support as the city recovers from the pandemic; and (b) To consider systems and processes in place to ensure effective transition from CAMHS to Adult

Item	Focus
	Mental Health Services (Recommendation from the Children and Young People Scrutiny Committee)
6. Health Inequalities	To consider how health inequality is measured, how factors which impact on health are established (including barriers to access) and where hot spots identified (geographical and community) and to scrutinise how partners work together to tackle particular aspects of health inequality[2]
7. Dental Services	To review access to dental services during the Covid-19 pandemic, the impact of reduced access and reinstatement of services, future dental provision contracts/ private and public treatment.

Reserve Items

Item	Focus
8. Alcohol dependency/ Alcohol related issues	Potential role of HSC in relation to impact on health when premises are licensed for sale of alcohol
9. Carer Support Services	To review support for carers during the Covid-19 pandemic
10. Gender reassignment services	Need for scrutiny and focus to be identified
11. Impact of Covid-19 on disabled people	Need for scrutiny and focus to be identified
12. 111 First	Changes to the service as a result of Covid

Healthwatch Priorities for 2021/22 – for information

[2] Following this to identify an area where scrutiny can add value by more detailed consideration at a future meeting(s), for example: BAME health experiences and access to services/ Poverty and the impact on health and access to services/ Support for those new to the city from other countries to access available NHS services/ Access to PEP medication to prevent HIV (pilot)/ Waiting lists in the context of health inequalities (see notes below funder impact of Covid on elective services from meeting with CCG 03/04/2021)

- **Long Term Conditions, primarily diabetes: management, education and support for patients**
- **Primary Care Strategy and Integrated Care Partnership strategy.**